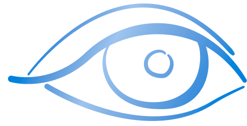

CONSENT FOR TREATMENT

I, by my signature below, grant permission for Heaton Eye Associates to render such care that the physician may deem appropriate in my/my child's treatment and diagnosis. I agree to my/my child's eyes being dilated if the doctor determines it is necessary.

I have read the NOTICE OF PRIVACY PRACTICES and have had any questions answered by this office. I understand that by signing this form I consent to the following:

- Sharing information for the purposes of treatment: My/my child's health information may be used by Heaton Eye Associates or disclosed to other health care professionals for the purpose of evaluating my/my child's health, diagnosing medical conditions, coordinating and providing treatment.
- Sharing of information for purposes of payment: My/my child's health information may be used to seek payment from my health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that I may use to pay for services.
- Sharing of information for purposes of operations: My/my child's health information may be used as necessary for business purposes to support the day-to-day operations of Heaton Eye Associates (including but not limited to the credentialing process, peer review, accreditation and compliance with all federal and state laws).

I hereby assign my health plan benefits or other applicable insurance benefits for medical/surgical treatment for myself/my child to Heaton Eye Associates.

I understand that I am responsible for compliance with the standards and regulations set forth in my/my child's health care plan and further understand that I will be responsible for all deductibles, non-reimbursable fees or fees for service not covered by my/my child's health care plan.

My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing. Any use or disclosure that has already occurred prior to the date of my revocation of consent will not be affected.

____

Patient Name (print please)

____

Signature of Patient/Guardian | Relationship to Patient | Date