I request that payment of authorized insurance benefits be made to Dr. Todd B. Lang, or services rendered by Bayside Eye Center. I authorize release of medical or other information needed by any health insurance company to determine benefits for services provided by Dr. Lang.

I certify that I assume full responsibility for all physician charges rendered to the above named patient, including but not limited to deductibles, co-insurance and any other amounts not covered by my insurance carrier.

I certify that if I am enrolled in any HMO, PPO, or any other health maintenance organization that requires any type of referral or authorization it is my responsibility to provide such information to Bayside Eye Center.

I understand that if Dr. Lang provides medical services and proper authorization is not obtained, I am responsible for payment if insurance is denied due to lack of prior authorization.

PROVIDERS OF MEDICAL BENEFITS ARE NOT REQUIERD TO WAIT FOR PAYMENTS FROM INSURANCE COMPANIES, INSURANCE CLAIMS, AND ARE FILED OUT OF COURTESY, NOT BY LAW.

Responsible Party Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIPAA**

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to maintain the privacy of your protected health information.

We are required to abide by the terms of the notice currently in effect. We reserve the right to change the terms of our notice at any time and to make the new notice provisions effective for all protected health information that we maintain. In the event that we make a material revision to the terms of our notice, you will receive a revised notice.

I am in receipt of the notice of privacy practices.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dilation Procedure**

The Florida Board of Optometry has adopted regulation 59V.3.010, which requires all patients to have a dilated eye exam upon their initial visit. If you have not previously been dilated under our care, we would then be required to perform this service. The dilating drops will require at least 20-30 minutes to take effect before the retina could be thoroughly evaluated. Without dilation, the presence of retinal holes, tears, diseases or systemic conditions affecting the eyes (i.e. diabetes, hypertension) may not be detected. We recommend accordingly.

The effects of dilation often include blurry vision at distance and near as well as increased light sensitivity, which may last 3-4 hours. Some people may find difficulty operating a motor vehicle.

Please check one of the following statements after reading and understanding all aspects of the dilation procedure.

\_\_\_\_\_\_\_\_\_I understand the above paragraph and elect to have my eyes dilated.

\_\_\_\_\_\_\_\_\_I understand the about paragraph and elect to NOT have my eyes dilated.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_