CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Brian M. Ross, OD, LLC
643 Ohio Street
Terre Haute, IN 47807
Phone 812-232-0073 Fax 812-232-0074

CONSENT FOR TREATMENT
I, the undersigned, hereby consent to the rendering of such care, including diagnostic procedures and medical treatment by employees and authorized agents of Brian M. Ross, OD, LLC and by its medical staff or their designees, as may, in their professional judgment, be deemed necessary or beneficial. I have had the opportunity to read this form, and I am satisfied I understand its contents and significance. I understand that I may withdraw my consent at any time.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
I authorize the office of Brian M. Ross, OD, LLC to release to my insurance carriers, including Medicare, any information required to file or resubmit my claim. I authorize all insurance carriers, Medicare, Medicaid, and Medicare supplements to provide any information required to resubmit any denied or incorrectly paid claims. This authorization remains in effect until withdrawn by me.

ASSIGNMENT OF INSURANCE BENEFITS
I hereby assign, transfer and set over to Brian M. Ross, OD, LLC, any and all benefits payable for treatment. I understand I am financially responsible to Brian M. Ross, OD, LLC for charges not covered by this assignment. I understand that my insurance carrier may pay less than the actual bill for services. I further authorize and request all insurance companies, including Medicare supplements, to pay the office of Brian M. Ross, OD, LLC directly on my behalf. I authorize application of the overpayment to any unpaid Brian M. Ross, OD, LLC bill for which I am legally responsible that has not been paid in full at the time of the receipt of overpayment.

FINANCIAL AGREEMENT
Because all glasses and contact lens orders are custom items, we expect payment in full at the time of service. Thank you! Our office gladly accepts Visa, Master Card, Discover, and American Express. Payment options are also available for any purchase of materials. However, balance must be paid in full before items are ordered. Any account over 30 days old will be subject to a finance charge. Full collection proceedings will be utilized for any account aging to 90+ days. In the event an account is sued, the patient (or financially responsible person) will pay all collection and/or Attorney fees.

________________ ____
Date **Signature of Patient, Legal Guardian or Auth Rep**

___________________ ____
Patient's age if minor **Signature of Guarantor**

If patient is unable to give consent, note reason: ____________________________________

Privacy Document Received

Initial Inside Box

1. **This is to inform you that Brian M. Ross, OD, LLC may use and disclose your health information that identifies you, and that consists of you past, present, or future physical or mental health condition, the provision of you health care, and the past, present, or future payment for the provision of your health care (this information is referred to herein as "Protected Health Information").**

2. **The use and disclosure of you Protected Health Information will be to carry out treatment, payment, and health care operations of Brian M. Ross, OD, LLC.**

3. **For a more complete description of how Brian M. Ross, OD, LLC may use and disclose your Protected Health Information, and to find out the specific meanings of "treatment", "payment", and "health care operations", please refer to Brian M. Ross, OD, LLC's Notice of Privacy Practices. You have a right to review the Notice of Privacy Practices prior to signing this Consent. The terms of the Notice of Privacy Practices may change from time to time; therefore, to obtain a revised Notice of Privacy Practices, please contact:**

   Sue Draper 643 Ohio St. Terre Haute, IN 47807 812-232-0073 suedraper@rossoptometry.com

4. **You have the right to request that Brian M. Ross, OD, LLC be restricted from using or disclosing you Protected Health Information in carrying out Treatment, Payment, or Health care Operations; however, Brian M. Ross, OD, LLC is not required to agree to your requested restrictions. If Brian M. Ross, OD, LLC does agree to your requested restrictions, then Brian M. Ross, OD, LLC must comply with your request. Please refer to the "Uses and Disclosures Without Consent or Authorization" section of the Privacy Notice.**

5. **You have the right to revoke this Consent. This revocation must be made in writing to Brian M. Ross, OD, LLC. This revocation will be valid except to the extent that Brian M. Ross, OD, LLC has taken action in Reliance of this Consent.**

By signing this document, you acknowledge that you have read and understand this Consent. Further, you hereby consent and authorize Brian M. Ross, OD, LLC to use or disclose your Protected Health Information in conjunction with Brian M. Ross, OD, LLC's Treatment, Payment or Health Care Operations in accordance with the terms of this Consent.

Signature (Patient) **Date**	**Signature (Authorized Rep)** **Date**
Printed	**Printed**
Signature (Witness)	**Relationship to Patient**

For Office Use Only Date of Revocation of Consent: _______________ Consent Revoked by: (Patient) (Other______________________)