MINNESOTA EYE CONSULTANTS, P.A.

OFFICE USE ONLY
PN: _____
DOS: _____

PATIENT AGREEMENT

Consent for Treatment
I authorize Minnesota Eye Consultants to assess and treat me, complete tests, and administer medications considered necessary or advisable. I understand that my healthcare provider is available to explain the purpose of any procedure and that I have the right to refuse, even if against medical advice.

I understand that my pupils may be dilated as part of the appointment. For some, dilation and other drops used during the visit may cause light sensitivity and blurry vision for a period of time.

Minors
A minor child needs an Agreement signed by a parent or guardian. By signing the Agreement, the parent or guardian assumes responsibility for information on behalf of the patient. It is strongly recommended that a parent or guardian accompany a minor to all appointments. Minnesota Eye Consultants reserves the right to request identification of any adult accompanying a minor. In the event that a parent or guardian is unable to accompany a minor to an appointment, please contact us at 952-888-5800, in addition to signing this form.

Release of Protected Health Information to Health Care Providers
☐ I authorize the release or retrieval of my health information, including prescription medication history and other information related to health care services for health care operations to or from third party pharmacy benefit payers, other health care facilities, and other providers who may be involved in my care and the continuation of my care for up to one year. A release may be revoked by me in writing at any time.

Communication
☐ I authorize Minnesota Eye Consultants to leave detailed voicemail at the phone number(s) I have provided.

Disclosure of Protected Health Information (PHI) to Specific Individuals
☐ I authorize disclosure of my health information, including appointment and billing information, to the following individual(s) involved in my care and the coordination of my care.

☐ Spouse / Significant Other: _____ ☐ Parent / Guardian: _____

☐ Child / Children: _____ ☐ Other: _____

If I would like a copy of my health information released to me or any individual(s), I will request and submit an Authorization for Release of Medical Information. A release may be revoked by me in writing at any time.

For medical records questions, please contact a medical records assistant at (952) 888-5800.

Research
☐ I understand that in order to provide patients access to the most advanced ophthalmic technology, Minnesota Eye Consultants works closely with numerous ophthalmic and pharmaceutical partners to participate in clinical trials and/or outcome studies involving the latest procedures, equipment and medications, and to teach other ophthalmologists about these advances. Medical records may be released for the purpose of medical or scientific research for up to one year unless revoked by me in writing at any time.

Notice of Privacy Practices
I acknowledge that I have been made aware of Minnesota Eye Consultants' privacy practices, which are posted in the waiting room. I understand that a copy of the Notice of Privacy Practices is available at my request, and if I would like a copy, I will ask for one.

Proprietary Interest
This is to inform you that your physician/surgeon may have a proprietary interest in the Minnesota Eye Laser and Surgery Centers. If you have further questions, please contact your physician or the Director of Surgical Operations.

Insurance Authorization & Assignment of Benefits
I authorize Minnesota Eye Consultants, on behalf of myself and/or my dependents, to furnish medical records and other information related to health care services provided by Minnesota Eye Consultants to Medicare, my insurance company or health maintenance organization, other payers, payer network organizations, including accountable care organizations, in which Minnesota Eye Consultants participate, and the contractors and third party administrators of any of these parties, as may be necessary for the payment of a bill, determination of benefits, utilization and quality review purposes, or health care operations. I hereby assign all authorized medical and surgical benefits to which I am entitled, and I request payment of all such authorized benefits be made on my behalf, to Minnesota Eye Consultants for any services furnished by Minnesota Eye Consultants.

I authorize Medicare, my insurance company or health maintenance organization, other payers, payer network organization, including accountable care organizations, and their contractors and third party administrators, to share my medical records and information obtained from Minnesota Eye Consultants, other providers from whom I have received services, or any other payer, payer network organization, including accountable care organizations, in which Minnesota Eye Consultants participates, and the contractors and third party administrators of these parties, as needed for payment and health care operations.

For insurance and billing questions, please contact a patient account representative at (952) 567-6063.

Routine vs. Medical Coverage
Office visits may be categorized as either "routine" or "medical". A comprehensive "routine" vision exam may contain the same elements as a comprehensive "medical" eye exam. The type of eye exam you have is determined by the reason for your visit, tests and/or procedures performed, and ocular pathology discovered during your visit. Routine vision exams typically produce diagnoses such as nearsightedness or astigmatism, while medical eye exams may produce diagnoses such as glaucoma or conjunctivitis. Please verify your routine and medical coverage with your insurance company.

Financial Responsibility
Minnesota Eye Consultants contracts with most major insurance plans; however, I acknowledge that it is my responsibility to confirm specific health plan coverage and benefit levels. I understand that I am financially responsible and agree to pay any charges for care rendered to me not covered by my insurance plan or if I do not have active insurance coverage. I agree that for services rendered to me by Minnesota Eye Consultants, I will pay my account at the time of service or upon insurance claim processing.

If payment plan consideration is necessary, I understand that it is my responsibility to call and make financial agreements satisfactory to Minnesota Eye Consultants for payment.

Any benefits of any type under any policy of insurance or any other party liable to the patient, is hereby assigned to Minnesota Eye Consultants. If copayments and/or deductibles are assigned by my insurance company or health plan, I agree to pay them to Minnesota Eye Consultants. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

By signing below, you acknowledge that you have read and understand the above Patient Agreement.

(Signature of Patient/Authorized Representative)	(Date)
(Patient Name)	(Date of Birth)