CASCADE EYE M.D.s
CONSENT FOR CARE AND TREATMENT
& FINANCIAL AGREEMENT

1. CONSENT FOR TREATMENT

I, patient/parent/authorized representative give permission for exam, diagnostic procedures, and medical treatment. Such services will be performed or prescribed by or at the direction of the attending doctor(s) and their designees as judged necessary for the medical care of the patient. This may include radiology, lab tests, sedation, and the use of local anesthesia. I also acknowledge that for the purposes of evaluation, my pupils may be dilated which may result in temporary blurred vision.

2. FINANCIAL AGREEMENT

I agree:

- To the release of all information needed by Cascade Eye M.D.s and/or their agents to obtain payment from my insurance company, health plan, or other third party payors.
- To assign to Cascade Eye M.D.s all insurance benefits payable for services rendered.
- To pay Cascade Eye M.D.s in a timely manner for any uncovered services or balance remaining after insurance benefits have been processed.
- To notify Cascade Eye M.D.s of changes to my insurance coverage, my address and/or phone number.
- That Cascade Eye M.D.s may charge me reasonable interest, late charges, costs and /or reasonable attorney fees should my account become overdue. I understand that if my account balance becomes past due and is sent to an outside collection agency, I will be responsible for any additional fees incurred.
- That any lawsuit for collection of my account will be brought in Snohomish County, Washington.
- That if a claim involves a third party Cascade Eye M.D.s will not negotiate with the third party. It is my responsibility to pay the bill on time, settle the dispute, and/or collect from the third party.
- There will be a charge of $25 if a check is returned to Cascade Eye M.D.s for non-sufficient funding.

NOTICE OF PRIVACY PRACTICES

A copy of the Cascade Eye M.D.s privacy policy is available upon request.

By signing below I am giving consent for care and treatment, and I acknowledge I am financially responsible for all charges including copays, deductibles, and charges that are non-covered or denied by my insurance company.

X_____ **X** _____

Signature (Patient or person authorized to give consent) Date

_____

Print your name

_____

If signed by person other than patient, provide relationship to patient, and name of patient

I give permission to discuss my medical information with the individual(s) named below:
(*NOTE: Cascade Eye M.D.s has the patient/guarantor sign this form on a yearly basis. The individuals listed below can be changed/updated at that time or can be revoked in writing at any other time*.)

1. _____ _____
Relationship to patient

2. _____ _____
Relationship to patient

For staff use only:

_____

Witness name/Telephone Witness name