DISCLOSURE LOG/INFORMED CONSENT

PATIENT NAME____**DOB**___________________

Insurance/Credit Policy: Our office uses the visual and medical codes in accordance with the standards set by Medicare and the Texas Insurance Board. We are happy to file the necessary forms with your insurance company when possible. Please understand that your insurance coverage is an **agreement between you, your employer and your insurance company.** We are not a party to that contract even though we are listed as a provider on your plan. All copays and contact lens fees are due at the time of service. Your insurance company does not guarantee payment to us. Payment for services not covered by your insurance company is your responsibility and you, the patient, agree to comply with this policy.

CARE CREDIT is available in this office and allows you to pay out for six months with no interest. This can be used for doctor's fees, extra testing and eyewear such as contact lenses or eyeglasses.

_______**Records may not be released to anyone other than for insurance purposes**

_______**Records may be released with permission to the following;**

Name: ____ **Date**_________________

____ **Date**_________________

____ **Date**__________________

____ **Date**__________________

____ **Date**__________________

_______**Records may be released with written permission to the following:**

Name: ____ **Date**___________________

____ **Date**____________________

____ **Date**____________________

____ **Date**____________________

Patient Consent of Private Health Information

I, the undersigned, authorize the release of medical and other information necessary for treatment, payment and health care operations in accordance with the Privacy Policy of this office. We respect our legal obligation to keep health information that identifies you and your family private.

Signature____**DATE**__________________

Representative of the Patient____