SERVICE WILL NOT BE PROVIDED TO ANYONE WHO CHANGES OR ALTERS THE TERMS OR LANGUAGE OF THIS CONSENT FORM

Authorization for Treatment

[Patient/Patient's legal representative] agrees to permit authorized personnel of Retina Center of Ohio [the Practice] to perform such diagnostic and therapeutic procedures that my treating physician(s) deem necessary for care. By signing below, I agree to permit examination and testing including vision testing, eye pressure, use of dilating drops, laboratory tests, imaging for treatment purposes, routine medical treatment (for example, medications, injections, drawing blood for tests) and emergency procedures as deemed necessary by physicians participating in my care. I understand that, except in an emergency, any further treatment or procedures will be performed only after I have been informed to the benefits, material risks and alternatives associated with such treatment or procedures and I have given my consent. I further understand that physicians, technicians, other healthcare and practice personnel may assist, be present and participate in providing my care and that my medical records may be used for educational purposes.

Authorization to Release Information

The undersigned hereby permits Retina Center of Ohio, its affiliated health care providers, and/or their authorized personnel to access and/or release all or any part of the patient information (including information regarding substance abuse, HIV testing, AIDS and psychiatric treatment) to, including but not limited to, the appropriate healthcare insurer(s), employers for work-related injuries, third party payor(s), students receiving education or training in healthcare and/or the Practice's agent(s), attorney(s), and/or consultants(s) for purposes including treatment of the patient, billing (or collecting payment) for services and healthcare operations including improving patient care, training or education students, performance improvement initiatives, discharge planning, risk management and/or as required by law.

Assignment of Benefits

In consideration of the Practice's and/or physician(s)' services received or to be received for medical/surgical services, I assign to the Practice and/or my physician(s), all benefits herein specified, not to exceed the above facility/practice/physician(s) charges. I direct such insurer(s) to pay such benefits directly to the Practice and/or my physician(s). I hereby agree to pay any and all facility and/or physician(s) fees that exceed or that are not covered by my insurance coverage including services deemed to be experimental or investigational, and waive any and all notices and demands in the event of non-payment.

Medicare/TRICARE/Champus Payment/Notice of Privacy Practices

I certify that the information given when applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim (including TRICARE/Champus claims). I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

Acknowledgments

1. I acknowledge that if I am a Medicare and/or Champus/TRICARE Beneficiary, I may request a copy of the notice from Medicare and/or Champus/TRICARE regarding my rights as a Medicare and/or Champus patient and that the form has not been altered.
2. I agree to release my Social Security number to the manufacturer of any medical device that I may receive, in accordance with Federal law and regulations. I further understand that my Social Security number may be used by the manufacturer to help locate me if there is a need to contact me regarding my use of a medical device. I release the Practice from any liability that might result from the disclosure of this information.
3. I hereby agree to be liable for and pay the Practice the difference between the established practice rate for expenses arising from surgery or hospitalization and the payment rate provided for in my benefits contract.
4. I acknowledge receipt of a copy of the Notice of Privacy Practices ("NOPP").

   If no, state reason acknowledgment of NOPP not received: _____

Record Retention

Retina Center of Ohio retains patient medical records in accordance with applicable law and pursuant to its record retention policies.

Computer Data Policy

I understand that my medical records will be accessible to authorized Practice personnel through computers and that the Practice will comply with certain safeguards established by federal, state and local law as well as Practice policy.

Certification

I certify that to the best of my knowledge and belief the information provided is complete and correct. I understand that this consent is subject to revocation by me at any time except if the person or entity authorized to make a disclosure has already acted in reliance on this form. Otherwise, subject to applicable law, this consent will expire at the same time the Practice's record retention period for this document expires.

Patient Personal Property/Payment for Non-Reimbursable Items

I understand that Retina Center of Ohio is not responsible for loss or damage to money and valuables, unless these are placed in the Practice safe. I understand and agree to pay the charges incurred by me or on my behalf for personal use and/or convenience items and hereby authorize the Practice to bill me or an applicable party for such use and I agree to pay or otherwise arrange for and ensure payment of the same.

Other Uses of Medical Information

The undersigned hereby understands and recognizes that Retina Center of Ohio, its affiliated health care providers, and/or their authorized personnel have access to medical information which may be used by RCO and its research personnel for research related purposes. The use of medical information for research related purposes is subject to Federal and State laws and regulations, as well as Practice policies regarding research studies.

Additional Permitted Uses and Disclosures of Confidential Medical Information

The undersigned understand and consents to disclosure of confidential medical information to a State or Federal Health Oversight Agency; an appropriate Public Health Authority; for purposes required by State and/or Federal law; in cooperation with a Law Enforcement Investigation; in cooperation with a domestic or child abuse investigation; to organ procurement organizations; and for any other permissible purpose as outlined in Retina Center of Ohio's Notice of Privacy Practices.

I AM THE PATIENT OR AUTHORIZED TO SIGN THIS DOCUMENT. I HAVE READ ALL OF THE ABOVE AND UNDERSTAND ITS TERMS.

_____

PATIENT Printed Name

_____ _____

Signature of Patient Date

_____ _____

Signature of Legal Representative (Relationship to Patient) Date

_____ _____

Witness Date