WillsEye Physicians
ACADEMIC MEDICINE

AUTHORIZATION FOR TREATMENT

The undersigned hereby consents to any medical treatment or hospital services rendered the patient under the general and special instructions of the attending physician and other assigned physicians or paraprofessionals providing care to the patient. I also acknowledge that no guarantee or warranty has been made by said physicians of Wills Eye as to the result of any treatment or procedure which may be given or performed. For the purposes of advancing medical education, I consent to the presence of observers to the patient's treatment.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Wills Eye is hereby authorized to release all or any part of the medical record including information concerning substance abuse, mental illness or HIV status of the patient named on this form for the purposes of treatment, payment, or operations. I authorize the use of my medical information for teaching purposes.

I certify that the information given by me in applying for payment under title XVIII of the Social Security Administration or its intermediaries or carriers or other third party payers, any information needed for payment of this or a related claim.

CONSENT TO PHOTOGRAPHY AND RESEARCH

I consent to having photographs and recordings of my image and voice, and I agree that upon creation, those images and recordings are owned by Wills Eye Hospital. I understand that I have the right to request that recording or filming stop at any time. I agree to release Wills Eye Hospital and its affiliates for the use of these images and recordings. Wills Eye Hospital is also a teaching and research institution. I understand that my medical information, including specimens, may be used in future educational and research activities. Clinical studies at Wills Eye Hospital go through a special process required by law that reviews patient welfare and privacy.

AUTHORIZATION FOR PAYMENT

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to Wills Eye and authorize Wills Eye to submit a claim to Medicare or other third party payer for payment.

FINANCIAL AGREEMENT

The undersigned agrees, whether he signs as a patient or the agent of a patient that in consideration of the service to be rendered to the patient, to be responsible for prompt payment of Wills Eye fees in accord with the regular rates and terms. I understand this agreement includes any amounts not covered by the patient's insurance.

The undersigned certifies that he/she has read the foregoing and is the patient, or is duly authorized as the patient's agent to execute the above and accept its terms.

I certify that the information shown on this form is true, correct, and accurate. I understand that payment and satisfaction of this claim may be from Federal and State funds and that any false claims, statements, or documents or concealment of material facts may be prosecuted under applicable federal and state laws.

_____ _____

Patient Name / Guardian / Agent Date

_____ _____

Patient / Guardian / Agent Signature Relationship