Michigan Glaucoma Specialists, P.C.

Richard L. Watnick, M.D. • Tom Obertynski, M.D. • Stephen P. Walters, M.D.

PATIENT ACKNOWLEDGEMENTS

Agreement of Responsibility

I understand that professional services, diagnostic tests and other medical services rendered to me are my financial responsibility or that of the patient's guarantor (the responsible party in the case of minors). I understand that I am financially responsible for all charges not covered by my insurance company. Also I understand I am responsible to fully understand how my insurance operates and if need be I will obtain a referral from my insurance company for my services. ***Otherwise the non-covered charges will be my responsibility***.

Eyeglass Prescription (Refraction):

I understand that a refraction is a service that is not covered by Medicare or most health insurance carriers. If my doctor provides a refraction with an eyeglass prescription, I understand I will be responsible for this charge, which is payable at the time of service. ***THE COST FOR THIS CHARGE IS $40.00***

Consent to Treat

I consent to care / treatment as prescribed by my physician as necessary in their judgement.

Release of Information / Assignment of Benefits

I authorize all my insurance submissions along with the release of my information needed to process my claim to my eligible insurance(s) for payment. I authorize payment to be issued directly to my provider for services rendered. **I also understand that I WILL** receive a monthly statement for any balance due to me.

HIPAA Compliance Patient Consent

Our notice of privacy practices provides information about how we may use or disclose your protected health information. Protected health information may be disclosed or used for treatment, payment or healthcare treatment by our practice or another provider to which you may be referred for additional care.

By signing this form I have read and understand all the statements above:

Patient Name:_____

Patient (Guarantor) Signature:_____