MEDICAL RELEASE/PAYMENT AUTHORIZATION/LIFETIME SIGNATURE on FILE/ Consent for Treatment

I authorize payments for all Medicare/Insurance benefits for services rendered by the Doctors of Texas State Optical College Station South be made directly to the doctors/office. I authorize this office to release to the centers for Medicare and its agents, and or other insurers, any information deemed necessary to determine the benefits payable for related services.

PLEASE NOTE: If you have a preexisting medical eye condition, (including but not limited to: Diabetes, Macular Degeneration, Cataracts, Neoplasms, etc.) or a medically related complaint, (including but not limited to: Redness, Itching, Vision Loss, Eye Pain, etc.), your visit will fall under a MEDICAL EXAMINATION and as such must be filed with your medical insurance. Routine Eye Care Benefits Plans such as VSP, Spectera, Avesis, Eyemed, etc. will not cover these diagnoses.

I understand that I am responsible for all charges incurred that are not covered by the insurance benefits. I also understand that I am responsible for co-payments and deductibles not covered by my insurance/eyewear benefits plan.

I hereby give consent for myself or my child to be seen/treated the Doctors of Texas State Optical College Station South. I understand that my eyes may be dilated and that dilation is now recognized as the Standard of Care.

This form will serve as a Lifetime Signature on File.

Signature: _____

Date: _____

Relationship to Patient: _____