TOWER CLOCK EYE CENTER

General Consent to Care:

- I understand that my condition necessitates a medical opinion or medical care. I consent to services, including diagnostic tests and procedures as well as medical treatment ordered by the physicians providing services to me.
- I understand that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me regarding the results of examinations or treatments to be provided to me.
- I understand that I may need additional testing, treatment and visits; I may be given instructions to follow at home.
- I understand that it is my responsibility to schedule and keep future appointments and to follow instructions indicated for care and treatment.

Consent to Practice Policies:

- I understand that the practice of Tower Clock Eye Center is to:
    - Send reminder to schedule appointments (phone, email, text or mail)
    - Notify patients of missed appointments by phone or postcard
    - Make one courtesy reminder call prior to scheduled appointments and after missed appointments. Messages may be left on voicemail or answering machine. You must notify us if you do not want to receive appointment reminders.
- I understand that I may be charged for missed appointments or appointments cancelled less than 24 hours in advance.
- I understand that I must provide accurate insurance information at each appointment in order for Tower Clock Eye Center to file a claim for me.
- I give my authorization to receive information on services offered through Tower Clock Eye Center.
- I give Tower Clock Eye Center consent to take a photo to be imported into my electronic medical record for identity purposes.

Agreement for Payment of Account:

- I authorize insurance payments directly towards Tower Clock Eye Center for services provided.
- If the insurer determines the care to be a non-covered service, I understand I am responsible for the entire charge.
- I understand that a credit balance on one charge may be applied to any other charge in my account.
- I will arrange a payment plan if I am unable to pay my account in full upon receipt of a statement.
- I agree that I am responsible for co-payments and charges placed to deductible, as well as any balance due after insurance payment and that I will pay these upon receipt of a statement.

Consent to Privacy Practices:
I have received a copy of Tower Clock Eye Center's Notice of Privacy Policies. I consent to the use or disclosure of my protected health information by Tower Clock Eye Center for the purpose of diagnosing or providing treatment for me, obtaining payment for my health care bills or conducting the health care operation of Tower Clock Eye Center.

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Signature of patient or authorized representative (relationship to patient) Date

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Print Patient Name