SOUTH JERSEY EYE PHYSICIANS

Permission to Treat

SJEYE chart _________________

I authorize South Jersey Eye Physicians P.A. (the "Practice") to evaluate and treat ________________________ (the "Patient"), for any vision or other problems related to his/her eyes. I also grant permission for the Practice to provide such treatment to the above named dependent in my absence, while he/she is being cared for and is accompanied by a family member or caregiver. I understand that this evaluation and treatment will include whatever ophthalmic testing and treatments that the Practice deems medically necessary.

I also authorize the Practice to disclose health information related to the above-named dependent's vision or other eye-related treatment to the family member or caregiver who accompanies the Patient to his/her appointment.

This permission will remain in full force and effect until the earlier of: (i) the Practice's receipt of written revocation of this permission by you; (ii) a material change in the Patient's condition such that either the scope of the evaluation or treatment changes; or (iii) one (1) year from today.

I further authorize the release of the Patient's medical record information to any such insurance companies, medical facilities, physicians, organizations or agencies for purposes of obtaining payment or any further treatment, as deemed necessary by the Practice. Notwithstanding this, I understand that, for disclosures that require an authorization pursuant to HIPAA, the Practice will provide me with a HIPAA-compliant authorization form.

Print Name: ___________________________ Date: __________________

Signature: ______________________________

Relationship to patient: parent legal guardian power of attorney (health care)

I understand that the Practice may request that I provide documentation evidencing such relationship.

Financial Responsibility

_________________________, in consideration of the services to be rendered to the above-named dependent, shall be financially responsible for any charges related to this visit, and any subsequent visits. I further understand that such charges may include insurance deductibles, coinsurance, or payment of the entire bill, if my insurance carrier denies coverage.

1 Child's name, address, ...

Name ____________________, ________________ __
last name *first name*

Address ____

____

____________________, _____ ________

email ____

Birthdate: ______________

Social Security # ______________

Tele *(home)* ______________

Tele *(cell)* ______________

Sex M F

1a Parent -or- guardian info

Name & address ______________, __________ __
(of parent/guardian) ____________________________

____

______________, ___ _______

email ____________________________

Tele *(home)* ______________

Tele *(cell)* ______________

Relationship

❏ Mother

❏ Father ❏ Other __________

2

Child referred to **South Jersey Eye Physicians** by:

____

3

Pediatrician / Family Physician (PCP) is: ______________________

address ______________________

____

______________, ___ _____

telephone # ______________________

4

Mother's name: ______________________

birthdate __________ SS#__________

address ______________________

______________, ___ _____

tele (home) ________________

tele (cell) ________________

tele (work) ________________

occupation: ______________________

employer: ______________________

email: ______________________

Father's name: ______________________

birthdate __________ SS#__________

address ______________________

______________, ___ _____

tele (home) ________________

tele (cell) ________________

tele (work) ________________

occupation: ______________________

employer: ______________________

email: ______________________

5

Please indicate if this visit is either Workman's Comp or Motor Vehicle Accident related:

❏ Worker's Comp

❏ Motor Vehicle Accident

6

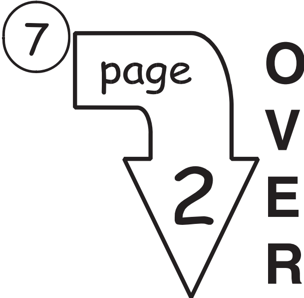
I authorize release of any medical information concerning this child's treatment to his/her insurance company, attorney or other doctor's office. I also authorize direct payment to South Jersey Eye Physicians, PA. I understand that, as these services are provided for my legal dependent, I am financially responsible for all charges, whether or not paid by insurance.

______________ ______________________________

(date) ***(parent / guardian's signature** -not child's signature)*

Please sign here

7



Please help us by recording your child's insurance information here. Thank you.

INSURANCE #1: Company: ______________________ ID #: ______________

Address---> PLAN: ______________

information is required to file insurance claims

This insurance is ...

(please check one)

- ... in child's name (boy child)
- ... in child's name (girl child)
- ...
- ...
- ... in parent's name (boy child)
- ... in parent's name (girl child)
- ... other (ex. guardian, grandmother, ...) ______________________

Subscriber information:

(might not be the child)

The "subscriber" for this policy (i.e. "name of insured") is:

____

The subscriber's employer is:

____

Sex: ___

Birthdate: ________

Soc Security # __________

information above is for the subscriber

INSURANCE #2: Company: ______________________ ID #: ______________

Address---> PLAN: ______________

information is required to file insurance claims

This insurance is ...

(please check one)

- ... in child's name (boy child)
- ... in child's name (girl child)
- ...
- ...
- ... in parent's name (boy child)
- ... in parent's name (girl child)
- ... other (ex. guardian, grandmother, ...) ______________________

Subscriber information:

(might not be the child)

The "subscriber" for this policy (i.e. "name of insured") is:

____

The subscriber's employer is:

____

Sex: ___

Birthdate: ________

Soc Security # __________

information above is for the subscriber