SUNY COLLEGE OF OPTOMETRY
UNIVERSITY EYE CENTER

UNIVERSITY EYE CENTER
33 W 42nd Street
New York, NY 10036
(212) 938-4001
universityeyecenter.org

Name:
DOB:
MRN:

Consent for Examination and Treatment

By signing below, I give my consent for University Eye Center ("UEC") to provide me with appropriate and medically necessary eye care services, including routine diagnostic and treatment procedures. To the extent that more complex and/or invasive treatment is required, I understand that the UEC will provide me with additional information so that I can provide informed consent for such procedures. I also understand that since the UEC is a teaching facility, residents and students may observe and/or assist in my care, under the direction of my treating clinician or other appropriate staff members.

I acknowledge that no guarantees have been made to me with respect to the results of any treatment or examination provided by the UEC.

I understand that photographs, video or other images (collectively "images") may be taken of me and used for medical purposes such as documenting or planning my care as well as for teaching or for publication in a scientific journal. We will obtain your authorization prior to any publication or disclosure of images which may identify you.

This consent has been fully explained to me and I certify that I understand its contents.

By: _____ Date: _____
Signature of Patient or Legal Guardian

If legal guardian, indicate relationship: _____

Research OPT-Out

☐ I DO NOT wish to be contacted regarding potential research studies. **Patients Initials**_____

Advanced Directives

Do you have an advanced directive? ☐ Yes ☐ No

Explain:_____

Acknowledgement of Receipt

By Initialing below, I acknowledge that I have been provided with a copy of:

- The Notice of Privacy Practices which details how certain health information about me may be used and disclosed by the UEC of the State University of New York, College of Optometry and how I may obtain access to and control this information;
- Patient bill of right and grievance procedures; and
- UEC Insurance and payment policies. **Patients Initials**_____

Signature on File / Payment Authorization

I request that payment for all services rendered by this facility be made on my behalf to the University Eye Center (UEC). I authorize the UEC to release to the Centers for Medicare and Medicaid (CMS) and its agents or any other insurer any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I understand that my signature will serve as a lifetime authorization for the release of medical information necessary to pay the claim. If another insurer is indicated in item 9 of the CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown.

I also understand that:

- If my insurance company requires a referral/authorization which is not available at the time of service, I will be financially responsible for the entire charge for the services rendered.
- I am responsible for all charges not covered by my insurance benefits, including the refraction charge.
- I have been given a copy of the UEC's insurance and payment policies and agree to abide by these policies.

Signature: _____ **Date:**_____