RIVER CITY
RETINA
CONSULTANTS

For Office Use Only
Acct #________

CONSENT TO MEDICAL CARE AGREEMENT

Thank you for entrusting River City Retina Consultants with your care. This consent form outlines the terms and conditions for medical care and treatment provided by our doctors. By signing this document, you acknowledge that you have read, understood, and agree to the information provided. This includes an understanding of our commitment to providing high-quality care, the nature of ophthalmic examinations and treatments, and your rights and responsibilities as a patient.

1. **Consent for Health Care Services:** I voluntarily consent to care that involves routine diagnostic tests, procedures, and medical treatment as prescribed by my physician and performed by River City Retina Consultants. No guarantees have been given by anyone as to the results that may be obtained. I consent to photographing, videotaping, video monitoring and audio devices for medical, safety or identification purposes. I understand that these will be stored in a secure manner that will protect my privacy. Images that identify me will only be released when authorized by me or as needed to provide for my continued medical treatment
2. **Authorization for Release of Information:** River City Retina Consultants may release information from my medical records to any health care provider involved in my care and treatment. River City Retina Consultants may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, the Medicare programs, and my employer's workers' compensation carrier. I acknowledge that upon the disclosure of medical record information to an insurance company or other payer pursuant to this authorization, River City Retina Consultants is no longer responsible for the confidentiality of any information known or possessed by the payer. I authorize River City Retina Consultants to file an appeal of a payment denial and/or request a hearing regarding any denial of payment for treatment provided to me. I further authorize the facility to present proof, utilize facility records and my records and documentation for appeals and hearings.

   - I will disclose specific individuals that River City Retina Consultants may share my medical information with in the Emergency/Alternate Contacts space of the demographic form. If I wish to add additional individuals, I will request and complete an Authorization for Release of Medical Records form. I understand that processing the form may take up to 30 days

   _______(Initials)

3. **Responsibility for Loss of Personal Articles:** I understand that River City Retina Consultants shall not be liable for the loss of or damage to any money, jewelry, documents, or any other items of personal property. Furthermore, I accept full responsibility for items of personal property kept in my possession.
4. **Behavioral Policies:** I understand and agree to adhere to the behavioral policies for River City Retina Consultants, encompassing all property, whether owned, leased, or rented, as well as online and in-person interactions. I also understand that any visitors who accompany me or communicate on my behalf are required to follow these same policies. I acknowledge that failure to comply with these guidelines may result in my dismissal from the practice and/or other actions deemed necessary by River City Retina Consultants.
A full copy of the policies is available upon request.
5. **Financial Agreement:** I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by River City Retina Consultants which are not paid by my health insurance or other payer. All charges are due and payable when I receive the bill. I understand that any credit or refund that I may be owed will be forwarded to the address on file with River City Retina Consultants. I understand that after reasonable notice, typically sent at 30, 60, and 90 days, delinquent accounts may be turned over to a collection agency and/or an attorney for collection. Should it be necessary to place this account in the hands of an attorney for collection, I agree to pay the costs of collection, including any court costs and a reasonable fee to the attorney employed by River City Retina Consultants to collect the account. I agree that the facility, its employees, agents, attorneys, and collection agencies, may call or text the cell number I provide for any reason, including but not limited to inquiring about the status and collection of my account. I also expressly authorize that each of them may use any mechanism including but not limited to

automatic dialing, artificial and pre-recorded voice systems.

Self-Pay Option

Additionally, I understand that I have the right to a “Self-Pay” visit in which my medical information will not be shared with my insurance company. Should I decide to do this, I will notify River City Retina Consultants as soon as possible.

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Patient or Authorized Person’s Signature

6. **Pre-authorization Requirements:** I accept the responsibility to obtain all referrals or pre-authorizations and to comply with all requirements of any insurance or medical coverage plan upon which I am relying for medical coverage of River City Retina Consultants charges.
7. **Assignment for Direct Payment:** I authorize that payment of any insurance (including auto insurance and health-care insurance) benefits for health care services or goods may be made directly to River City Retina Consultants.
8. **Calling, Texting, and Emailing:** I agree that all telephone numbers and email addresses I provide to River City Retina Consultants may be used by River City Retina Consultants or those acting on its behalf to communicate with me by telephone (including cell phone), unencrypted text messages, or any automated or prerecorded messages. I understand that such unencrypted text messages may be intercepted by unauthorized individuals and I understand and accept the risk of using unencrypted communications. I will be given an option to opt-out or unsubscribe from most communications. For those communications that don't offer an opt-out or unsubscribe option, I will call the office at (502) 897-9881 and ask to be removed from the list.

We will not communicate protected health information via text or email.

- Mobile Opt in, SMS Consent, and phone numbers collected for SMS communication purposes will not be shared with any third party or affiliates for marketing purposes.

I acknowledge that:

- **I have read this form and understand its contents.**
- **I am the patient, or person duly authorized either by the patient or otherwise, to sign this agreement, consent to, and accept its terms.**
- **I am responsible for the payment and/or co-payment that is due at the time of service.**
- **I have received, or have been offered, a copy of River City Retina Consultant’s HIPAA Policy.**
- **If applicable, I designate the following person as my personal representative.**

______________________	______________________	____________
Authorized Person’s Name	Authorized Person’s Signature	Date
______________________	______________________	____________
Patient Signature or Authorized Person	Patient's Name or Authorized Person	Date

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We have made every effort to obtain a written acknowledgment of receipt of our Privacy Notice from the patient. It could not be obtained for reasons detailed below:

□ Patient refused or unable to sign
□ Other ____________________

Employee Name ______________________ Date ____________