AUBURN CATARACT AND EYE CLINIC, LLC
JEFFREY L. WEEKS, M.D.
2871 CORPORATE PARK DRIVE, OPELIKA, AL 36801

CONSENT FOR MEDICAL AND DIAGNOSITIC TREATMENT

I wish to receive treatment at Auburn Cataract and Eye Clinic (ACEC) and I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his medical judgment. I understand that this care may include examinations, tests, medical and surgical treatment. No guarantees have been made to me about the outcome of this care. I understand that photographs or films may be taken during the course of my treatment to be made a part of my medical record. I do not object to the taking of these photographs or films.

RELEASE OF INFORMATION

I, the undersigned as the patient or his/her authorized representative, authorize ACEC to release to my insurance company (ies) or their authorized representative or other appropriate agency (ies) that information which is necessary to validate my claims for payment purposes. This includes my employer if workers' compensation is claimed. ACEC is also authorized to release to my physician(s), or the persons authorized to bill for them, such information as necessary for billing purposes, including, without limitation, all records and information pertaining to my medical treatment (including that for drug & alcohol abuse), laboratory and other diagnostic tests results, therapy, diagnosis and prognosis.

FINANCIAL RESPONSIBILTY AND ASSIGNMENT OF INSURANCE

I understand that professional services are rendered to the patient and the patient is responsible for charges incurred for these services. Payment for annual deductibles and co-insurance may be collected at the time of service. I understand that I am financially responsible for all charges not covered by my insurance company, including a NO-SHOW charge of $25.00 for appointments not cancelled or rescheduled at least 12 hours before my scheduled appointment time. I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, attorney fees and/or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State. I agree, in order for ACEC to service my account or to collect monies I may owe, ACEC and/or agents may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. I may also be contacted by text messages or emails, using any email address I provide to ACEC. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing devices, as applicable. This assignment will remain in effect until revoked by me in writing.

I permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due.

AUBURN CATARACT AND EYE CLINIC, LLC
JEFFREY L. WEEKS, M.D.
2871 CORPORATE PARK DRIVE, OPELIKA, AL 36801

I hereby authorize ACEC, its agents, employees, and affiliates to have access to my complete medical records for the purpose of performing its management functions and as they deem necessary.

I understand that my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If "other health insurance" is indicated in item nine of the CMS-1500 claim form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of the information to the insurer or agency shown. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for deductible, co-insurance, and the uncovered service. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

PHARMACY BENEFIT MANAGEMENT (PBM)

Electronic-Prescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy. Medication history Transactions provide the physician with information about medications that the patient is already taking prescribed by any provider, to minimize the number of adverse drug events. By signing this consent, I am agreeing that ACEC can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for optimal treatment purposes.

AUTHORIZED PATIENT NOTIFICATION LIST

I authorize ACEC to discuss any aspect of my care, to include: appointments, tests, test results, surgical procedures, prescriptions, and any other pertinent information pertaining to my care with the follow designated people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

In the event that any of the selected representatives that I have designated change, it will be my responsibility to notify ACEC in writing by stating who I would like to have removed or added to the Authorized Notification List.

_____ _____ _____
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE TIME

_____ _____
PRINT NAME OF PATIENT OR PERSONAL REPRESENTATIVE DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY