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EYE CARE SERVICES CONSENT AND INFORMATION RELEASE FORM

Residents who live in nursing facilities often have unmet eye care needs. Vision impairment is a common chronic condition. Many suffer needlessly from undetected glaucoma, cataracts, or retinal disease. Others have a slow loss of vision simply because their glasses prescriptions have not been regularly checked and updated. Regular eye care services provided at the nursing facility offer several benefits to residents and their families. It reduces the need for outside transportation and allows an examination to be performed in a more comfortable environment for the patient. Also, when visual abilities are improved, the quality of life of the resident is improved.

Medicare, Medicaid, private insurance, and private payment cover the professional fees for these services.

Lifetime Consent Agreement
The patient, legal guardian or health care surrogate authorizes Mobile Eye Care Solutions or its representative to examine the eyes and treat, if necessary, the patient listed below. This consent may be withdrawn at any time.

Notice of Privacy Practices
I have received information regarding privacy practices that explains my rights concerning protected health information. **Copy of our Notice of Privacy Practices is available on our website www.eyecare2u.com**.

Medicare/Medicaid Authorization
I request that payment of authorized Medicare and/or Medicaid and/or other insurance benefits be made to Mobile Eye Care Solutions or its representative. I authorize any holder of medical information about me [patient] to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Medicare Supplemental Insurance Authorization (Medigap)
I request that payment of authorized Medicare Supplemental Insurance benefits (Medigap) to be made to Mobile Eye Care Solutions or its representative. I also authorize any holder of medical information about me [patient] to release to the below named Medicare Supplemental Insurance (Medigap) any information needed to determine benefits payable for services from this provider.

_____ _____ _____
Resident's Name Name of Responsible Party Signature of Responsible Party

_____ _____
Nursing Facility Date

Do you wish to have access to your patient records ___Yes ____No Email address: _____

I authorize Mobile Eye Care Solutions (MECS), and its providers to view my external prescription history via eClinical Works EHR system. I understand that this includes but is not limited to prescription history from other unaffiliated medical providers, insurance companies, and/or pharmacy benefit managers may be viewable by provider and staff of MECS. This may also include prescriptions dating back several years.

_____ _____
Responsible Party Date

Please Complete and Return