LASERCARE EYE CENTER

Responsible Party Information Form

This Form is to be Completed by the Responsible Party if the Patient is a Minor (below age 18) or not legally competent

My Name: _____ Patient's Name: _____
My relation to Patient:_____ Am I legally authorized to provide consents for the patient? ☐Yes ☐No
If no explain_____

My SS#: _____-_____-_____ Date of Birth: _____/_____/_____
My Home Phone: (_____)_____-_____ My Employer:_____
My Home Address: _____ My Work Phone: _____
_____

PARENTAL INFORMATION

Complete if the patient is a minor and you are not their biological par-

Name of Father: _____ Date of Birth: _____/_____/_____
Home Phone: (_____)_____-_____ SS#: _____-_____-_____
Home Address_____ Employer:_____

Name of Mother: _____ Date of Birth: _____/_____/_____
Home Phone: (_____)_____-_____ SS#: _____-_____-_____
Home Address_____ Employer:_____

MEDICAL AND FINANCIAL AUTHORIZATIONS

General Acknowledgement of Guardianship

Please read this form carefully then sign the bottom.
I am the patient's parent, spouse, legal guardian or other relation legally authorized to provide consent for the patient by the State of Texas. I understand I am providing consent for examination and/or procedures on behalf of the patient. I am agreeing to be financially responsible for all medical charges on behalf of the patient. I understand the consents and assignments of benefits listed shall remain in effect until revoked by me in writing. A photocopy of the assignments shall be considered as valid as an original. I acknowledge the data on the new patient information form is accurate.

Financial Agreement and Assignment of Benefits

I authorize payment directly to assignee (LaserCare Eye Center and Sidney Gicheru, MD) for health insurance benefits otherwise payable to the patient. I authorize assignee to provide information pertaining to the patient's claims to the insurance company. I understand it is my responsibility to know the patient's insurance coverage and limitations. I understand I am ultimately responsible for all medical charges. If the insurance fails to pay a claim within 45 days or rejects a claim as "non-covered", a bill will be sent to me and I agree to pay the bill. Failure to pay the bill promptly will result in the assignee reporting me to a Collection agency or seeking legal action against me. I understand it is my responsibility to pay any deductible, co-payment or other outstanding balance not paid by the insurance company. I understand **all charges must be paid at the end of each visit**, with the exception of charges covered by Medicare or Insurance. **I understand the assignee does not accept Insurance or Medicare as payment for Refractions or Contact Lens exams/supplies.**

Medicare and Medigap Assignment of Benefits

I request payment of authorized Medicare and Medigap benefits be made on the patient's behalf to the assignee for services furnished the patient. I authorize holders of medical information about the patient to release to Health Care Financing Administration (HFCA), Medigap insurance company or their agents any information needed to determine these or related benefits.

Medical Treatment Consent

I authorize examination of the patient by physicians and the staff of assignee. I authorize performance of all procedures the judgement of the above-named staff may deem necessary. I authorize the administration of anesthetics and analgesics (including eye drops) which the above named staff deem advisable. Should I elect to refuse a specific procedure, I agree to sign a release absolving LaserCare Eye Center and Sidney Gicheru, MD of all liability related to my refusal. I understand if the patient's eyes are dilated it may not be safe for the patient to drive.

Signed : _____ **Date**: _____
(Parent or Legal Guardian)