ANNAN
RETINA EYE CENTER

Consents and Agreements

Authorization to access electronic prescriptions

I hereby authorize Annan Retina Eye Center (AREC) to view my external electronic prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefits managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years, and may include prescriptions to treat HlV, substance abuse and psychiatric conditions, if applicable. I understand that my prescription history will become part of my AREC medical record.

Authorization for Photograph and Use in Medical Records

I hereby authorize and consent to the taking of photographs or pictures of me by AREC and its agents or employees, and the use and storage of such photographs for identification purposes and as part of my medical record.
I hereby release AREC its staff, agents and employees from all liability related to the making, storage and use of such photographs for identification purposes as part of my medical record.

Video Surveillance

This form provides you with notice that this location is under video surveillance. The images and moving pictures captured herein will be stored on a server. You understand and agree that AREC is not responsible for breach or theft of such images and/or moving pictures, provided a reasonable effort is made to safeguard it.

Referral to outside providers

You understand and agree that if your insurance company requires you to have a referral for service provided by out of network providers, you are responsible for obtaining this. The physician(s) and provider(s) at AREC may refer you to providers that are out of network for you. lf you desire to be referred only to in-network providers, then you may contact your insurance company for a list of active in-network providers for the relevant service and we would happy to help you select from within that list.

Consent to Treat

l, the undersigned, voluntarily consent to and authorize AREC through its physicians, employees and/or agents to provide such medical care and examinations, on a continuing basis, and to administer such routine diagnostic, radiologic, and/or therapeutic procedures, tests, and treatments as are considered necessary or advisable, in my diagnosis, care and treatment, in the judgment of my AREC physician(s), including, but not limited to, collecting and testing of bodily fluid, and administration of pharmaceutical products. I acknowledge that no guarantees have been made to me about the results of any examination or treatment.

I consent to pharmacologic dilation of my eyes by the use of eye drops. I understand that this is a very commonly performed step in ophthalmic examinations, but that there are uncommon but potentially serious side effects. These may include, but are not limited to, angle closure and glaucoma, headache, cardiac arrhythmia (usually temporary if it occurs), and hypopnea. lF I AM PREGNANT OR THINK I MIGHT BE PREGNANT, I WILL NOTIFY THE STAFF MEMBER OR PHYSICIAN IN PRIVACY BEFORE DILATION DROPS ARE INSTILLED lN MY EYES. While dilation drops are likely to be generally safe during pregnancy due to the small quantity and route of administration, extra precautions are taken during pregnancy to minimize and/or delay exposure.

Release and Assignment of Benefits

I directly assign all health insurance benefits, to which I am entitled, by Medicare, Medicaid, Blue Cross, or any other insurance plans, directly to the provider(s) in JSRC for the services rendered on my behalf. I understand that I am financially responsible for all charges, whether or not I am insured at the time of service, including deductibles, co-insurance, co-payments, and benefit services that are out of network, denied and/or not covered by my health insurance plan. I authorize AREC or any other holder of medical or other information about me to release to Medicare, Medicaid, or Blue Cross or any other insurance carriers or their authorized agents any information needed for this or a related claim.

PATIENT SIGNATURE:_____ **DATE:** _____

OR RESPONSIBLE PARTY:_____ DATE: _____

Printed Name of Patient