Consent for Treatment

Meredith Morgan University of California Eye Center /Tang Eye Center at University Health

I voluntarily give my permission to the healthcare providers of the Meredith Morgan University of California Eye Center /Tang Eye Center at University Health and such assistants and other health care providers as they may deem necessary to provide medical services to me. I understand by signing this form, I am authorizing them to treat me as long as I seek care from the Meredith Morgan University of California Eye Center /Tang Eye Center at University Health providers or until I withdraw my consent in writing.

Patient / Guardian Initial : _____

Statement of Financial Responsibility

Meredith Morgan University of California Eye Center /Tang Eye Center at University Health

I acknowledge that I am legally responsible for all charges in connection with the care and treatment provided by representatives of Meredith Morgan University of California Eye Center /Tang Eye Center at University Health. I assign and authorize payments to Meredith Morgan University of California Eye Center /Tang Eye Center at University Health. I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions coverage limits, lack of authorization or medical necessity.

I understand that I am responsible for fees not paid in full, co-payments, policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law.

Patient / Guardian Initial: _____

Consent to Communicate Via E-mail - E-mail is not HIPAA Compliant

I voluntarily give my permission to the Meredith Morgan University of California Eye Center /Tang Eye Center at University Health to communicate with me or my child _____ via e-mail. This communication could include but is not limited to: appointment reminders, spectacle /contact lens 'ready for pick-up' notifications, spectacle/contact lens prescriptions (by request) and exam reports or evaluations. I give this permission understanding the e-mail may be unencrypted and therefore is not secure. E-mail contents and attachments may be read by unintended recipients.

YES I give permission to communicate using this address _____
Patient / Guardian Initial: _____

NO I do NOT want any communication to occur via e-mail for _____
Patient / Guardian Initial: _____

Patient Signature: _____ **Date:** _____

(Parent, Guardian)
Print Parent Guardian Name: _____ **Relationship** _____

A duplicate, scanned or faxed copy of this form is considered the same as the original document.
If you would like a copy of this document ask and we will provide you with one.