CONSENT TO TREAT

I voluntarily consent to any and all treatment and procedures for myself or the individual(s) for whom I am responsible provided by Dr. Clement and/or his assistant and I further state that I understand that no guarantee has been or can be made as to the results of treatments or examinations at Carolinas Eye Center _____***Initials***

INFORMATION REGARDING DILATING EYE DROPS *(if needed)*

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, driving an automobile, or operating machinery, is not advised until the effects of the drops have worn off. Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Wesley Clement and/or such assistants as may be designated by him/her to administer dilating eye drops, if needed. The eye drops are necessary to diagnose my condition. _____***Initials***

SUMMARY NOTICE OF PRIVACY PRACTICES & ACKNOWLEDGEMENT OF RECEIPT:

Under federal law, Carolinas Eye Center is required to protect the privacy of certain parts of your protected health information (PHI) we hold in our files. Upon your request, Carolinas Eye Center must give you a notice (referred to as our "Notice to Privacy Practices") of our legal duties and privacy practices concerning the permitted uses and disclosures of your PHI and your rights regarding our use and disclosure of your PHI. You have the legal right to review our Notice of Privacy Practices before you sign this consent. You have the right to request us to restrict how we use and disclose your PHI for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement with you. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your PHI on reliance of your consent. By signing this form, you are granting consent to Carolinas Eye Center to use and disclose your PHI for the purposes of treatment, payment, and health care operations.

I hereby acknowledge that I have been provided this Summary Notice of Privacy Practices and understand that I may at any time request to receive the full Notice of Privacy Practices from Carolinas Eye Center. _____***ACCEPT*** _____***DECLINE***

FINACIAL POLICY/CONSENT TO RELEASE:

I understand that I am responsible for all medical expenses, regardless of insurance coverage. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient by Carolinas Eye Center and Dr. Wesley Clement. If your health plan determines a service to be "not covered", you will be responsible for the complete charge or remaining balance. Payment is due upon receipt of that statement. **Co-payments are due at the time of service.**

I have read and understand the financial policy set forth by Carolinas Eye Center, and I agree to be bound by its terms. I also understand and agree that such terms may be amended periodically by the practice. _____***ACCEPT***_____***DECLINE***

PATIENT(print name):_____

PATIENT SIGNATURE:_____

If minor, RESPONIBLE PARTY SIGNATURE:_____

Relationship:_____

DATE:_____