CALIFORNIA VISION AND VISAGE

CONSENTS/AGREEMENTS

1. Consent to Care.
   I consent to be treated by physicians providing services for the California Vision and Visage Medical Group. While I am a patient, I permit my doctor(s), their staff, and all the persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care may include tests, examinations, and medical treatment. I understand and acknowledge that no guarantees are made to me about the outcome of this care. I understand that additional consents must be obtained by the treating physician if non routine procedures are to be performed.
2. Financial Agreement
   I understand that charges for any diagnostic test will be in addition to the consultation fee, and that I am directly financially responsible for all charges incurred for medical services and/or surgical procedures rendered for myself and/r my dependents, which are not covered by valid insurance benefits. I agree to pay any legal interest, collection expenses, and attorney's fees and other costs incurred, should it become necessary to assign any amount I may owe for collection.
3. Assignment of Benefits
   I authorize payment directly to California Vision and Visage of all medical insurance payments to which I am entitled for medical services and/or surgical procedures rendered by California Vision and Visage or the physician and staff.
4. Medicare Authorization to Release Information and Payment Request
   I certify that the information given by me in applying for payment under Title XVIII of the Social Security act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medical claim. I request that payment of authorization benefits be made on my behalf. I assign benefits payable for physician services to the physician or organization furnishing the services.
5. Release of Information of Benefits
   I authorize release of any information acquired in the course of my examination or treatment, which may be needed for the payment of professional charges and related services.
6. Personal Affirmation
   I certify that all statements given to the physicians and personnel are complete and accurate to the best of my knowledge. A copy of this agreement shall be considered as effective and valid as the original agreement will continue until revoked by me in writing.

_____	_____	_____
Patient Name	Patient/Guarantor Signature And Relationship	Date

_____	_____	_____
Witness Signature	Date	Remarks