



Well Eyecare Physician, LLC

Consent for Medical/Optometric/Ophthalmic Treatment

Patient Name -----

Date of birth-----

This consent permits Well Eyecare Physician, LLC and its affiliated providers to provide routine vision care, medical eye examinations, and urgent care to the patient based on the recommendations of a licensed optometrist or ophthalmologist associated with Well Eyecare Physician. The care may encompass, but is not restricted to, examinations, treatments, dilation, and fittings for contact lenses and eyeglasses, including follow-up appointments or referring to another eyecare specialist.

Name of Authorized Person/Patient-----

Signature -----

Date-----

I am the legal guardian of the patient mentioned above. I possess the legal authority to consent to medical, optometric, and ophthalmological care for this patient. I hereby grant permission for Well Eyecare Physician to deliver medical care to the patient without the presence of another guardian. I acknowledge my responsibility to provide any required information concerning insurance coverage, and I accept accountability for any services and fees incurred that are not covered by insurance. I understand that this consent will remain in effect from this date onward unless I revoke it in writing.

Patient/ Guardian name-----

Patient/Guardian signature-----

Date-----



Well Eyecare Physician, LLC

Insurance Assignment Policy and Agreement

By signing this document, I confirm that I have been informed of the Insurance Assignment Policy. I authorize Well Eyecare Physician LLC to serve as my agent in utilizing my insurance and/or Medicare Plan for reimbursement purposes, and I consent to the direct payment of these benefits to Well Eyecare Physician, LLC, on my behalf for any services and materials rendered. I grant permission to any holder of my medical records to disclose the information required to assess benefits for related services. Should I possess additional insurance, my signature permits the release of essential medical information to the insurer or agency and empowers Well Eyecare Physician, LLC to function as my agent as described above. In the event that my insurance does not cover any part of this visit or any materials, I acknowledge my responsibility for payment for these services or materials. This authorization remains effective for my lifetime unless revoked in writing.

Patient Name: -----

Guardian name: -----

Patient/Guardian Signature----- Date-----

Prescription Access Notice and Consent for electronic delivery/ Eyeglasses frame selection

1- Well Eyecare Physician provides access to prescriptions for contact lenses and eyeglasses, which can be obtained in paper or digital form.

2- A paper version of the eyeglasses or contact lens prescription is available following the eye exam or at any point thereafter.

3- I confirm that I have received this notice and understand that I can access my prescriptions for glasses and contact lenses.

4- Patients may opt to select from the eyeglass frames available at Well Eyecare Physician, LLC during their visit, or they can shop for eyeglasses online or at other local optical stores. I understand that I will be responsible for the payment of the frame material that is not covered by insurance.

Patient Signature: ----- Date: -----

Guardian Signature: ----- Date: -----



Well Eyecare Physician, LLC

Patient information and acknowledgments

Name-----

Gender-----

Date of Birth-----

Age-----

Social Security number-----

Ethnicity-----

Subscriber Insurance information

Subscriber Name-----

Date of Birth-----

Relationship to insured-----

Social security No:-----

Vision insurance carrier-----

Insurance ID:-----

Medical Insurance carrier-----

Insurance ID:-----

Notifications

I acknowledge that I will receive telephone and email communications from Well Eyecare Physician, LLC. I understand that I can revoke my consent to receive these notifications at any time by informing Well Eyecare Physician, LLC in writing.

☐ I consent

☐ I do not consent

I consent to receive text messages from Well Eyecare Physician, LLC. I acknowledge that I will be liable for any charges imposed by my mobile carrier for these messages,

and I can revoke my consent at any time by providing written notice to Well Eyecare Physician, LLC.

☐ I consent

☐ I do not consent

I acknowledge that I have been made aware of the HIPPA notice of Privacy Practices.

Initials-----

Patient/ Guardian Representative Name-----

Patient/Guardian Signature -----

Relationship to Patient-----

Date: -----

All health insurance providers, including Medicare, mandate that Well Eyecare Physician, LLC gather a comprehensive medical history of the patient.