Eye Care
PHYSICIANS & SURGEONS
of New Jersey

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Michael Munoz, M.D.
Kimberly Tischner Miller, O.D.
Barbara Schmaltz Eiferman, O.D.

CONSENT FOR TREATMENT

The undersigned hereby consents to any medical services rendered to the patient by the physicians, employees and contracted healthcare providers of Eye Care Physicians and Surgeons of New Jersey.

AUTHORIZATION TO RELEASE INFORMATION

The undersigned authorizes Eye Care Physicians and Surgeons of N.J. to release all or any part of the medical record of the patient named on this encounter form to other healthcare providers, insurance companies, organizations, or agencies as may be concerned with the diagnosis, treatment or payment of the medical services rendered. The undersigned also authorizes other healthcare providers to release all or any part of the medical record of the patient named on this encounter form to Eye Care Physicians and Surgeons of N.J. in patient's diagnosis and/or treatment.

ASSIGNMENT OF INSURANCE BENEFITS

As a convenience to our patients, Eye Care Physicians and Surgeons of N.J. will bill your insurance carrier directly. I hereby assign, transfer and set over to Eye Care Physicians and Surgeons of N.J. all of the rights, title and interest to medical, automobile personal injury protection, or workers compensation medical insurance benefits, and all other rights and privileges otherwise payable to me for those services provided. I also understand that obtaining precertification, authorization or other requirements or conditions of my insurance coverage is my responsibility.

HIPAA PRIVACY POLICY

The undersigned acknowledges that he/she has received a copy of Eye Care Physicians and Surgeons of N.J. Notice of Privacy Policy as required by HIPAA.

FINANCIAL RESPONSIBILITY

The undersigned agrees, whether signing as the patient or an agent, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to be responsible for all or any unpaid portion of the bill incurred. I further understand the unpaid portion of the bill may be insurance deductibles, coinsurance, copayments or the entire bill, if my insurance carrier denies coverage.

The undersigned certifies that he/she has read the foregoing and understands its terms and is the patient or is a duly authorized representative of the patient and accepts and consents to the above terms.

_____ _____

Signature of patient/authorized representative Date

_____ _____

Witness Date

73 S. Main Street
Medford, NJ 08055
609-654-6140
Fax: 609-714-0371

Cinnaminson Medical Center
1701 Wynwood Drive
Cinnaminson, NJ 08077
856-829-0600
Fax: 856-829-2832

The Pavilions of Voorhees
2301 Evesham Rd. • Suite 503
Voorhees, NJ 08043
856-770-0030
Fax: 856-770-0840