



Dr. Paul M. Wehner and Associates, P.C.

**CONSENTS, RELEASES AND AGREEMENTS**

\_\_\_\_\_,  
LAST name FIRST name Date

**NOTICE OF USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

I understand that Eyes at Bethany Village (EaBV) may use or disclose my protected health information to diagnose or provide treatment for me, to obtain payment for health care expenses, or to conduct health care operations. "Protected health information" includes information created, maintained, or received by EaBV that identifies me, or from which my identity could be determined, and which relates to my past, present or future physical or mental health, condition, treatment, or payments for medical services.

I acknowledge that I have been provided with EaBV's Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that may occur in my treatment, payment of bills, or in the performance of health care operations of EaBV, as well as my individual rights and the duties of EaBV with respect to my protected health information.

EaBV reserves the right to change the privacy practices that are described in its Notice of Privacy Practices. EaBV will post any revised Notice of Privacy Practices in its office. In addition, I may obtain a revised Notice of Privacy Practices by contacting EaBV and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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**RESEARCH SCREENING AUTHORIZATION**

I understand this screening authorization allows EaBV to inform me when a research project or drug study is available which may benefit me. I understand I will be offered, in writing, the chance to participate in any such study prior to any information being shared with non-clinic personnel. I understand I can refuse to participate in any study offered and I may revoke this authorization at any time.

- Yes, please contact me  No thank you, do not contact me

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**ALL INSURANCES: ASSIGNMENT OF BENEFITS AND PAYMENT AUTHORIZATION**

I authorize payment directly to EaBV of all benefits otherwise payable by any insurance policy(ies) and I hereby irrevocably assign such benefits to EaBV in an amount not to exceed the charges for services rendered. I agree to be financially responsible for charges denied by insurance, and understand that benefits quoted by my insurance company are only estimates and not a guarantee of payment. If my indebtedness for such charges is placed with an attorney or agency for collection, I agree to pay EaBV reasonable attorney's fees and collection expenses.

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**FINANCIAL GUIDELINE**

I have received and read the Financial Guidelines for Eyes at Bethany Village, and I understand and agree to its terms and conditions.

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By signing below, I acknowledge that I have read, understand and agree to the terms and conditions outlined in this Consents, Releases and Agreements Form.

X \_\_\_\_\_  
Patient / Guardian Signature Date