Levenson eye associates

LevensonEyeAssociates.com | 904-366-3781

Jeffrey H. Levenson, M.D.
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Ronald Singal, M.D.
Elizabeth McLeod, M.D.
William Knauer, M.D.

AUTHORIZATIONS

Patient Name (please print): _____ Date of Birth: _____

- I hereby authorize and request the medical treatment necessary for the care of the above patient.
- I authorize **LEVENSON EYE ASSOCIATES** to use and disclose protected health information to complete the treatment, payment, and healthcare operations for the above patient. I understand this may include the release of all medical records to the referring and family physicians and to my insurance company. If necessary, I allow the fax transmittal of my medical records.
- I acknowledge full financial responsibility for services rendered at **LEVENSON EYE ASSOCIATES**. I understand payment is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of a default of payment of my charges.
- I further authorize and request that insurance payments be made directly to **LEVENSON EYE ASSOCIATES** if they elect such an arrangement.
- I acknowledge that I have received notice of the Privacy Practices. A copy is in the front of the office.
- I acknowledge my phone, and email may be used to relay information regarding appointments, test results, and other information.
- I authorize **LEVENSON EYE ASSOCIATES** to store my photo and identification information.
- I agree that **LEVENSON EYE ASSOCIATES** may record an exam visit. Under no circumstances may a patient, patient representative, or visitor take a recording of another patient, patient representative, or visitor without explicit permission.
- I certify that the information I have provided is true and accurate, and I understand and agree to all the patient responsibilities previously outlined.

☐ I have read and understand the above consent for treatment, for the release of protected health information, for financial responsibility, and for insurance authorization.

_____ _____

Patient / Parent or Guardian Signature Date

Riverside Park Place
751 Oak Street
Suite 200
Jacksonville, FL 32204

Mandarin
3020 Hartley Road
Suite 190
Jacksonville, FL 32257

Orange Park
905 Park Avenue
Suite 104
Orange Park, FL 32073

Ponte Vedra Beach
120 A1A North
Suite 102
Ponte Vedra Beach, FL 32082

Knauer Building
2535 Riverside Avenue
Jacksonville, FL 32204