THE EYE CENTER
AT SOUTHERN COLLEGE OF OPTOMETRY
1225 Madison Avenue
Memphis, TN 38104-2222
901-722-3250

Authorization for Treatment & Financial Responsibility Form

Patient Name: _____

Address: _____Zip Code: _____

Daytime Phone Number: _____

Social Security#: _____Date of Birth: _____

If there are charges not covered by your insurance, who is responsible for paying the bill?

Name of Responsible Party: _____

_____

Address: _____

Phone Number: _____

A spectacle/contact lens prescription cannot be released if there is an outstanding balance on the patient's account.
How will you settle your account today? ❑ Cash ❑ Check ❑ Credit Card

In the event of an emergency, who should we contact?

Name: _____

Phone Number: _____

I authorize the performance of examinations, treatments, and/or referrals by Staff Doctors in The Eye Center at Southern College of Optometry including the use of non-physician extenders (i.e. interns/students) as deemed appropriate in their professional judgement.

I acknowledge that The Eye Center and Southern College of Optometry may use any information obtained from this examination for educational and research purposes, provided that individual identities, rights and liberties will be protected. Further, I grant permission to release any information necessary for payment of claim by any insurance company.

The Eye Center assumes no responsibility for the qualification of the patient or family for Medicare, TennCare, or insurance benefits and the undersigned shall be responsible to The Eye Center and Southern College of Optometry for payment of all services and supplies furnished to the undersigned, or the dependent of the undersigned.

Patient signature, if not a minor: _____Date: _____

If patient is a minor, parent/legal guardian sign here: _____Date: _____

If patient is a minor, agent for the Legal Custodian: _____Date: _____