Please Sign All Three

(If you have insurance or not)

Guarantee of Payment & Authorization to Submit Insurance Claims

I certify that the information given by me in applying for health insurance payment and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my other insurance (as indicated on a HCFA-claim form or electronically submitted claim) and/or Medicare benefits, and I request that payment of these benefits be made to Dr. James M. Tickner for any services or materials furnished. I authorize any holder of medical information about me to be released to the centers for Medicare, Medicaid or any other additional insurances and its agents in order to determine appropriate benefits for related services. I also understand that submission of a claim to my insurance company does not guarantee payment and that I am responsible for payment if my insurance company does not cover the claim or service. If I have no vision insurance then I will pay for the services provided from Dr. Tickner today and for any future services provided. Should it be necessary to turn my account over to a collection agency, I agree to pay all collection fees, court costs and reasonable attorney's fees in addition to the balance due.

Signature: _____

(Lifetime Patient Signature)/ *Relationship to the patient if not the patient*

HIPPA Privacy Acknowledgement Receipt

I acknowledge that I received/ reviewed a copy of Dr. Tickner's Notice of Privacy Practices.

Signature: _____

Authorization for a Dilated Eye Exam

A dilation means your eye doctor will use eye drops to temporarily enlarge your pupils. Dilation is important to rule out glaucoma, diabetes, high cholesterol, migraines, high blood pressure, floaters, flashes of light, and many other eye diseases.

It is recommended that you bring someone to drive you. Some sensitivity to light may occur and although rare one might experience an allergic reaction to the drops. Dilation drops can range from 3-6 hours for most drops but can last up to 24 hours.

Do you want your eyes dilated at this time: *YES* *NO*

Signature:_____ Date: _____

No Show FEE:

If you are unable to make your appointment, please call and re-schedule so that other patients can be accommodated. If you do not show up for your appointment and do not call to cancel at least 24 business hours prior to your appointment, you will be charged a $20.00 no show fee and $10.00 for a contact lens check.

Signature:_____ Date: _____