E. Watts Davis, OD
Evan W. Davis, OD

Eye Care Associates

Stephen Mitchell, OD

1431 West 10th Street
Laurel, MS 39440
Phone: 601-649-1437
Fax: 601-649-1431

825 Jefferson Street
Monticello, MS 39654
Phone: 601-587-2452
Fax: 601-587-9457

519 Mississippi Dr.
Waynesboro, MS 39367
Phone: 601-735-2878
Fax: 601-735-2879

Financial Agreement

I acknowledge that payment is due at the time of treatment, unless other arrangements have been made. I accept the financial responsibility for all charges not covered by my insurance company. Past due accounts will be referred to a collection agency and credit bureau.

Patient or Legal Guardian **Date**

Authorization for Treatment

I hereby authorize and request examination and/or medical treatment by the physicians and the staff of Eye Care Associates. I further authorize any procedure that the judgment of the above named physicians and staff may deem necessary during any treatment. I also authorize the administration of any anesthetics and analgesics, which above physicians and staff deem advisable.

Patient or Legal Guardian **Date**

Medicare Assignment & Supplement

I authorize Eye Care Associates to release to the Centers of Medicare and Medicaid Services information about me needed to determine benefits payable for related services. I request that payment of authorized Medicare and Medicaid be made to Eye Care Associates for services furnished to me by their physicians. I realize this is a lifetime authorization.

Patient or Legal Guardian **Date**

Insurance Assignment

I request that payment of Insurance benefits be made to Eye Care Associates for services furnished to me by their physicians. I realize this is a lifetime authorization. I also authorize release of any medical information to my insurance company listed above.

Patient or Legal Guardian **Date**

Consent to Send or Receive Medical Records

Eye Care Associates has my consent to use and disclose my health information for the following purposes: to provide medical service and treatment alternatives, to collect payment for services rendered, for healthcare operations, to contact you with appointment reminders, and to inform you of health-related products and services.

Patient or Legal Guardian **Date**

Picture Consent

I authorize Eye Care Associates to obtain a photo of myself to be kept in my medical records for the purpose of identification and medical documentation.

Patient or Legal Guardian **Date**