Memorial Hospital
725 Glenwood Drive
East Building - Suite 892
Chattanooga, TN 37404
Phone: 423-624-3937
Fax: 423-629-6505

Eyecare Associates, P.C.

Hixson Office
4511 Hixson Pike
Hixson, TN 37343
Phone: 423-870-3742
Fax: 423-877-9494

Steven A. Jaworski, O.D. Patrick J. Bowers, Jr., M.D. Charles L. Sanders, Jr., O.D.
Caroline Vollberg Misch, O.D.

PPO/HMO PARTICIPATION, INSURANCE FILING & ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

The doctors in our group participate in many PPO and HMO plans. I understand that if my insurance plans is one of the doctors do not participate in, my benefits may be reduced or not cover the services.

I understand that my insurance requires specific facilities for surgery, etc. Please advise us and we will try to abide by their requirements. However, we cannot be responsible in the event that care/testing is done at a non-provider facility.

I understand that if my insurance plan requires a referral to be seen by the doctor, it is my responsibility to provide this information at the time of my appointment. I understand that I will be responsible for any charges if I do not follow the guidelines required by my insurance company.

I understand that the doctors will be happy to file my insurance for surgery or office surgery, with an assignment of benefits. Payment for services rendered, however are ultimately the responsibility of the patient and are not contingent upon the insurance settlement. PPO and HMO plans, that the doctors participate in, will also be filed for office charges, however, I will be asked to pay deductibles, and co-insurance at the time of service.
The information I have given is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including reasonable attorney's fees and costs of collection in the event of default.

I authorize payment of medical insurance benefits that I have, to be paid directly to the above doctors. I authorize the release of any information necessary to process my claims.
I understand it is my responsibility to let the above doctors know of any change in my address or telephone number.

I hereby give my consent for treatment.

If l am a minor, I authorize you to release information concerning my medical care to my parent/s or legal guardian. (Patient must also sign below)

Sign _____
Date _____

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Signature below is only acknowledging that you have read or received our office Notice of Privacy Practices:

Print Name _____ Signature _____

Date _____

If acknowledgement could not be obtained from patient, please document the reasons below:

_____

_____

_____

Informed Consent to Release or Discuss Clinical/Financial Information

I authorize _____ (family member or friend) to act on my behalf and make decisions regarding my clinical or financial affairs while I am a patient of Dr's Jaworski, Sanders, Bowers, and Vollberg. I release the above named physicians from any and all liability regarding privacy of medical information, insurance information or financial information.

Signature of patient _____ Signature of witness _____