NEW PATIENT
CONSENT FORM

_________________________________ _____________________
Patient's Name DOB

Consent for Necessary Medical Treatment: Recognizing the need for healthcare services for the patient whose name appears on this form, consent is hereby given to Gerhard W. Cibis, MD, PC, to provide healthcare services, treatment, diagnostic testing, and procedures deemed necessary by the practice, its physicians, employees and agents, for the safety, welfare, and the health of the patient.

Video Photo Consent: Dr. Cibis may deem it necessary to obtain a video image of the patient's eyes. At times, the video may show things not appreciated clinically. It documents treatment progress and important parts of the exam: eye alignment (strabismus), need for glasses (refractive error), and fixation. In some cases, the photos may be used for teaching and publications purposes. The subject of the image would not be identifiable.

There is an additional fee for the video photo documentation that **may or may not be covered by my insurance carrier.** I understand that I may be financially responsible for this service. I also understand that I have the right to revoke this consent, but must do so in writing.

I decline the video photo documentation.

Insurance Coverage: I understand that insurance companies differentiate between ophthalmic examinations for medical conditions and routine eye examinations. The doctor is legally required to determine whether my exam is medical by my complaints/diagnoses/clinical findings. Therefore, each visit will be filed to medical insurance for medical diagnoses. This is mandatory and not negotiable. I understand that my portion, co-pays, and deductibles will differ depending on the category of examination the doctor is forced to choose.

I hereby authorize Gerhard W. Cibis, MD, PC, to furnish information to insurance carriers concerning my illness and treatments, and assign to physician all payments concerning medical services for myself and dependents. I understand that I am responsible for any amount not covered by my insurance.

_________________________ ____________________ __________
Signature of patient/legal guardian Relationship Date

10/2015