PATIENT/PHYSICIAN AGREEMENT

Your Eye Specialists is dedicated to providing patients with high quality eye health care. Please read the following paragraphs, and confirm that you have read, understood, and agree to our practice policies set forth below by initialing next to them.

Patient Privacy:
I have read the Notice of Privacy Practices set forth by Your Eye Specialists, and I understand and agree to the policies described in that document.

Patient Initials: _____

Financial Policy:
I have read the Financial Policy set forth by Your Eye Specialists and I understand and agree to the policies described in that document.

Patient Initials: _____

Form Completion Policy and Charges:
There will be a fee for the completion of forms at the rate of $25 per completed page (up to a maximum of $50). Forms incurring this fee include: FMLA (Family and Medical Leave Act), disability forms, back-to-work forms, and miscellaneous forms. The completed forms will be returned to the patient upon receipt of appropriate payment.

Patient Initials: _____

Failure to Follow Physician Orders:
You, the patient, are expected to comply with a physician's orders to manage medical disease and/or symptoms. In the event that the patient does not follow physician's orders, the physician shall be released from any injury or illness claim resulting from the patient's failure to follow orders, and the patient may be discharged from the clinic. Not following physician orders includes, but is not limited to, missing follow-up appointments, as well as missing or postponing or refusing additional tests which may rule out/confirm/discover illness. I have read this policy from Your Eye Specialists regarding following physician orders, and I understand and agree to comply with these policies.

Patient Initials: _____

If you have any questions regarding this agreement, please contact us at (954)452-9922.

I have read and understood the above patient/physician agreement from Your Eye Specialists and agree to abide by all aspects of this agreement.

Signature:_____ Today's Date: _____

Patient Name:_____ Date of Birth: _____