248 S Florissant Rd St. Louis, MO 63135

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EYE CARE SERVICES CONSENT AND INFORMATION RELEASE FORM

Residents who live in nursing facilities often have unmet eye care needs. Vision impairment is a common chronic condition. Many suffer needlessly from undetected glaucoma, cataracts, or retinal disease. Others have a slow loss of vision simply because their glasses prescriptions have not been regularly checked and updated. Regular eye care services provided at the nursing facility offer several benefits to residents and their families. It reduces the need for outside transportation and allows an examination to be performed in a more comfortable environment for the patient. Also, when visual abilities are improved, the quality of life of the resident is improved.

Medicare, Medicaid, private insurance, and private payment cover the professional fees for these services.

Lifetime Consent Agreement
The patient, legal guardian or health care surrogate authorizes Mobile Eye Care Solutions or its representative to examine the eyes and treat, if necessary, the patient listed below. This consent may be withdrawn at any time.

Medicare/Medicaid Authorization
I request that payment of authorized Medicare and/or Medicaid benefits be made to Mobile Eye Care Solutions or its representative. I authorize any holder of medical information about me [patient] to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Medicare Supplemental Insurance Authorization (Medigap)
I request that payment of authorized Medicare Supplemental Insurance benefits (Medigap) to be made to Mobile Eye Care Solutions or its representative. I also authorize any holder of medical information about me [patient] to release to the below named Medicare Supplemental Insurance (Medigap) any information needed to determine benefits payable for services from this provider.

____________________ ____________________ ______________________________

Patient Name Name of Responsible Party Signature of Responsible Party

____________________________ _______

Nursing Facility Date

Medicare # _________________ Medicaid # ___________________ MCD Applied For?: __

Other Insurance: ___________________ Other Insurance # ___________________

Please Complete and Return