Edmonds Eyecare Associates

Acknowledgement and Consent

_____I acknowledge that I have received a copy of Edmonds Eyecare Associates Notice of Privacy Practices.

_____I authorize insurance benefits to be paid directly to Edmonds EyeCare Associates and recognize that I am responsible for payment in full of non-covered services or materials on the day of my appointment. I authorize Edmonds Eyecare Associates to release any information necessary to process any insurance claims.

_____I authorize Edmonds Eyecare Associates to communicate with me by USPS mail, email, phone, and/or text.

Email_____

Phone Number (_____)_____ ☐ **HOME** ☐ **WORK** ☐ **CELL**

Phone Number (_____)_____ ☐ **HOME** ☐ **WORK** ☐ **CELL**

Please include the names of persons with whom we are allowed to discuss your condition and/or billing information with:

Name:_____ Relationship_____

Name:_____ Relationship_____

Name:_____ Relationship_____

By signing below, I agree that I have reviewed and understand the information above.

Patient Name_____Date Of Birth_____

Signature_____Date_____

(Parent or Guardian signature if patient is a minor)

Andrew P. Davis, M.D.
General Ophthalmology
Cataract Surgery
Glaucoma Surgery

Bryan S. Karrick, O.D., F.A.A.O.
Primary Eye Care
Medical Eye Care
Contact Lens

Ben M. Stoebner, O.D., F.A.A.O.
Primary Eye Care
Medical Eye Care
Urgent Care Vision

Glen R. Owen, O.D., F.A.A.O.
Primary Eye Care
Medical Eye Care
Glaucoma

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