Columbia Eye Surgery Center, Inc.
1920 Pickens St, Columbia, SC 29201
(803) 254-7732

PATIENT SIGNATURE FORM

Patient Name______________________________________**Account#**____________________

I acknowledge that I have been given a copy of the **Patient Bill of Rights** form:

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Patient or Representative Signature Date

I acknowledge that I have been given a copy of the **Notice of Privacy Practice:**

____
Patient or Representative Signature Date

AUTHORIZATION/RELEASE/ASSIGNMENT

I hereby authorize and request the payment of services from Medicare, Medicaid, and/or other insurance plans or payers be made on my behalf to the Columbia Eye Surgery Center, Inc. I hereby assign to the Columbia Eye Surgery Center, Inc. all payments for services. **I understand that I am responsible for paying any co-payment, co-insurance, and deductible not paid by my insurance coverage.**

I hereby authorize the release of medical information to Medicare, Medicaid, and/or other insurance plans or payers. I also authorize the release of medical information to other healthcare providers for the purpose of treatment.

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Patient or Representative Signature Date

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Witness Date