Medical Records Release & Payment

Patient Name: (Last) _____ (First)_____ DOB:_____
Patient Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____ Email: _____

Guarantor Name: (Last) _____ (First)_____ DOB:_____
Relationship to Patient: _____
Guarantor Address: _____
City: _____ State: _____ Zip: _____
Guarantor Phone #: _____ Email: _____

Insurance Company:
Member ID: _____ Group#: _____ Date: _____

I authorize Dr. Joseph Uyeda and Associates, P.C. to release my medical records upon written request, for the purpose of Health Care Operations (including, but not limited to, provider review functions, claims payment, prescription, workman's comp., and quality assessment).

I am financially responsible for the professional fees and diagnostic testing involved in the ocular examination for the service date(s) listed above. I understand that my insurance may not cover (partial or total) fees involved in the office visit or related testing. I am financially responsible for any return fees, financial charges, collection fees, or attorney fees. I authorize and give willing permission for my credit card to be charged for the amount **not** covered by my insurance (up to $_____) company or charges applied to my deductible for up to 60 days from received written response from the insurance company.

Initial which plan you prefer:

Plan A	Plan B	Plan C
Leave credit card information. We will submit to insurance. Credit card will only be charged if insurance sends the payment responsibility back to the patient.	Leave the check with amount in full. We will submit to insurance and check will only be cashed if insurance sends the payment responsibility back to the patient.	Pay platinum member price (10% discount on office visit). We will not submit to insurance. *HRT and VF not discounted

Credit Card type: _____ Name on Credit Card: _____
Credit Card #: _____ Exp: ___/___/___ Security Code: _____

Date: ___/___/___
Print Name: _____ Signature:_____

-OR-

Check#: _____