Wang Vision Institute Authorizations

Your doctor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you regarding appointments, follow-up care, payment, or other issues related to your care. If this contact is made by phone and you are not at home or at work, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you when deemed necessary by our office.

_____ By intialing here, I authorize the Wang Vision Institute staff to contact me regarding appointments as stated above.

Any time the Doctors or staff of Wang Vision Institute contact you, for example to thank you for a referral or for attending a seminar, this is considered "marketing". Due to changes in privacy laws, we must have your authorization to send you such materials. From time to time our practice works with marketing organizations to make you aware of products or services that you may have an interest in purchasing. The doctors and staff at Wang Vision Institute may need to use your health information including your name, address, phone number, and your clinical records for the purpose of marketing products and services to you.

_____ By intialing here, I authorize the Wang Vision Institute staff to contact me regarding products or services that I may have an interest in purchasing based on my health information, or to contact me regarding referrals.

At this time, we are not accepting insurance, and payment for all services is expected the day of your visit. In cases of refractive surgery, your carrier is likely to determine that the procedure is "not medically necessary, and therefore, not covered". For those patients coming for medical reasons or for whom further testing is deemed necessary by the doctor, we are happy to supply the superbill for you to submit to your insurance to request reimbursement, we but do not deal with insurance companies directly. Should further tests be recommended, it is your decision whether to accept the recommendation and pay for these services that day, or seek further testing elsewhere. It is your responsibility to be informed and understand the benefits set forth by your insurance carrier regarding your medical benefits.

_____ By intialing here, I acknowledge that I understand all fees for service will be my responsibility, and that while I may request reimbursement from my insurance, they may not reimburse me.

_____ By intialing here, I authorize Wang Vision Institute to publish any photographs, maps, or pertinent information concerning any care as may be needed for professional medical journal, books, or seminars in the interest of medical education, knowledge, and research. I understand that I will not be mentioned by name, nor will I be identifiable from my photographs.

By signing below, I acknowledge that I have received a copy of the Wang Vision Institute's privacy notice.

_____	_____
Patient Name (Printed)	Date
_____	_____
Patient Signature	Authorized Provider Representative
_____	_____
Personal Representative (Printed)	Personal Representative Signature