HORIZON
EYE PHYSICIANS

CONSENT FOR CARE AND TREATMENT:

I understand that Patient, which may be defined as me, my child or a child for whom I have legal responsibility, needs medical care and treatment and I consent to such treatment at Horizon Eye Physicians, LLC. Treatment provided by medical providers, nurses, and medical assistants at Horizon Eye Physicians, LLC may include evaluation and management, laboratory and other testing; routine medical, nursing and medical assistant care and procedures. I give permission to the medical team to obtain any records, may it be medical charts, laboratory results, and pharmacy medications records deemed necessary for my care. I understand that photos or video of Patient may be taken in connection with such treatment and for operational, and quality improvement.

No Guarantee: I acknowledge that no guarantees or warranties have been made with respect to treatment or services to be provided by Horizon Eye Physicians, LLC. I understand that all supplies, medical devices and other goods provided to Patients are provided by Horizon Eye Physicians, LLC as is.

Specimen Disposal: I acknowledge that Horizon Eye Physicians, LLC may, in its sole discretion, remove, retain, or dispose of any tissue or body parts removed from Patient.

Text Messaging: I understand that Horizon Eye Physicians, LLC can provide notifications to my cell phone. These texts are Do Not Reply texts for informational purposes only and are not intended as a form of two-way communication. I acknowledge that standard text messaging rates and fees will apply. Messages may include private health and billing information protected under federal and state law. Messaging utilizes a public telephone network and full encryption and security is not guaranteed, and any person with access to my phone will be able to see these messages unless I take steps to protect my phone with a password or PIN. I will have the ability to opt out of text messages at any time by using the STOP function.

Accessing Pharmacy Information: I agree that if a Horizon Eye Physicians, LLC employee or provider needs to access my pharmacy information that they have my permission to do so.

PATIENT'S NAME: _____

PATIENT'S DATE OF BIRTH: _____

PATIENT/GUARDIAN SIGNATURE: _____

DATE: _____ TIME: _____