OAKLAND EYE CARE

Ophthalmologist
Thomas W. Biggs II, D.O.
Arlin H. French, D.O.
Stefanie D. Sherman, M.D.

Optometrist
Ashley M. Wesley, O.D.

Authorization and Agreement for Medical Treatment

Consent for Examination and Treatment

I understand that medical treatment may be necessary for the patient by the physician and their technicians. I understand that the examination procedures will be explained to me and I shall consent to the partial or complete examination. I understand that the examination results will be provided to me with recommendations. The responsibility for any follow-up examination to check abnormalities found and treated, lies with me and not my physician or their technicians.

For patients less than 18 years old, a parent or legal guardian must sign all consent forms giving the physician and their technicians permission for medical treatment.

Patient Responsibilities

Thank you for choosing us as your eye care provider. We are committed to you and the success of your treatment. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we request you read and sign prior to your treatment.

1. It is necessary that all patients complete the patient information forms prior to seeing the doctor.
2. Full payment is due at the time of service, unless we participate with your insurance company, including all co-pays, deductibles, and non-covered services. We accept cash, check, debit and credit cards (Visa and MasterCard). Patients will be charges a $35.00 fee for any check returned to us. Any unpaid balances may be referred to an outside collection agency for past due accounts.
3. Our office will submit claims to your insurance company as a service to you. Your insurance carrier cannot be billed unless you provide necessary documentation. We will only accept assignment of benefits for insurance plans we participate with. Any remaining balances after payment is received from your carrier are your responsibility and not that of your insurance carrier.
4. Due to the specialized nature of our practice, we provide some services that are not covered by all insurance carriers. The staff will review these additional fees with you if we are aware of them. It is important that you know what your insurance plan covers since we cannot know coverage of all insurance plans.
5. HMO patients are responsible for obtaining the required referral prior to their office visit.
6. If your insurance company requires laboratory specimens to be sent to a specific lab, please know the participating lab, and inform us. Be advised that laboratory charges are separate from our office.
7. A parent or guardian must accompany all minors. The adult accompanying a minor will be the responsible party for the payment of any services rendered.

I authorize: 1) Medicare or any other insurance plan to pay benefits directly to Oakland Eye Care, P.C. And 2) The release of my medical information to my insurance company to process my claims.
I agree to pay, at the time of service, for: 1) All services not covered by my insurance plan, 2) All services not authorized by my HMO, and 3) the co-payments and deductibles of my insurance plan, unless other payment arrangements have been made.

Patient Signature _____ Date _____

Parent or Guardian Signature _____ Date _____

Revised: March 11 2026