MAXWELL LOW VISION CLINIC
AUTHORIZATION FOR BENEFITS

I AUTHORIZE THE CENTER FOR THE VISUALLY IMPAIRED TO PROVIDE ME WITH SERVICES WITHIN THE CLINIC'S SCOPE OF PRACTICE WHILE I AM A PATIENT OF THIS FACILITY.

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS FROM MEDICARE BE MADE TO THE CENTER FOR THE VISUALLY IMPAIRED FOR SERVICES FURNISHED BY THIS FACILITY.

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NEEDED TO DETERMINE THESE BENEFITS TO THE HEALTH CARE FINANCING ADMINISTRATION.

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS FROM MY COMMERCIAL INSURANCE COMPANY TO BE MADE TO THE CENTER FOR THE VISUALLY IMPAIRED FOR SERVICES FURNISHED BY THIS FACILITY.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE MAXWELL LOW VISION CLINIC'S NOTICE OF PRIVACY PRACTICES.

____

PATIENT NAME (PLEASE PRINT)

X____

PATIENT OR REPRESENTATIVE SIGNATURE

____

REPRESENTATIVE'S RELATIONSHIP TO PATIENT

____

DATE

AUTHORIZATION TO RELEASE INFORMATION

I hereby agree and consent for any agency that has information of a medical, social, or psychological nature concerning my condition to release this information to the Center for the Visually Impaired (CVI). I also agree and consent for CVI to, in turn, release information concerning me that is of a medical, social, and/or psychological nature as needed by other cooperating agencies. Material released may or may not contain information related to infectious disease status. All information will only be used by professional persons for the purpose of aiding my rehabilitation. Unless indicated, this release will be valid for twelve (12) months from the date below.

Signature ______________________________

Print Name ______________________________

Date ______________________________

Witness ______________________________

Center for Visually Impaired
Release of Medical Records

Patient

Name: ______________________ Patient ID: ______________________

Phone: ______________________ Email: ______________________

Address: ____

Transfer From

Doctor: ______________________ Hospital/Clinic: ______________________

Fax: ______________________ Email: ______________________

Address: ______________________ Phone: ______________________

Transfer To

Recipient: ______________________ Company: ______________________

Fax: ______________________ Email: ______________________

Address: ______________________ Phone: ______________________

Authorized Information to Disclose

- [ ] Diagnoses — Date: ______________________
- [ ] Prescriptions/Medications — Date: ______________________
- [ ] Alternative Treatments — Date: ______________________
- [ ] Eye Exams — Date: ______________________
- [ ] ______________________ — Date: ______________________

Method of Transfer

- [ ] Fax
- [ ] U.S. Mail
- [ ] ______________________

Reasons for Disclosure

- [ ] Legal Requirement
- [ ] Insurance Claim or Dispute
- [ ] New Care Provider
- [ ] Specialist Consultation/Second Opinion
- [ ] ______________________

I, the patient, understand that I may revoke my consent at any time. I understand that my information will be held in the strictest confidence and will be read, shared, and held by no parties other than those who transfer the information and those who receive it.

______________________ ______________________

(Patient's Signature) (Date)

______________________ ______________________

(CVI Representative) (Date)

ASSUMPTION OF THE RISK AND WAIVER OF LIABILITY
RELATING TO CORONAVIRUS/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization, a national emergency by the President of the United States, and a state emergency by the Governor of Georgia. **COVID-19 IS EXTREMELY CONTAGIOUS** and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend hygiene practices, use of masks and social distancing and have, in many locations, restricted the number of people that may congregate as a group at any given time.

The Center For the Visually Impair, Inc. ("CVI") offers programs and services for the visually impaired directly or through tenants and subcontractors at its facilities located at 739 W Peachtree St NW, Atlanta, GA 30308 (the **"CVI Facilities"**). CVI has put in place preventative measures to reduce the risk of the spread of COVID-19 at the CVI Facilities. The measures apply to services and programs offered at the CVI Facilities directly by CVI and by its tenants and subcontractors. By signing this agreement, I agree that I and my child(ren) will comply fully with such preventative measures. However, I acknowedge that CVI **cannot guarantee** that I or my child(ren) will not become infected with COVID-19 when we enter the CVI Facilities for any purpose, and that visiting the CVI Facilities and participating in the programs and services offered **could increase** my and my child(ren)'s risk of contracting COVID-19.

By signing this agreement, I acknowledge the extremely contagious nature of COVID-19 and voluntarily assume the risk that I and/or my child(ren) may be exposed to or infected by COVID-19 by visiting the CVI Facilities or by participating in the programs and services offered, and that such exposure or infection may result in personal or bodily injury, illness, temporary or permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 either by entering the CVI Facilities or by participating in the programs and services offered there may result from the actions, omissions, or negligence of myself and/or others, including, but not limited to, CVI or its agents, employees, representatives, volunteers, subcontractors or tenants (collectively, **"CVI Parties"**) or by program and service participants and/or their families.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to my myself and/or my child(ren) (including, but not limited to, personal or bodily injury, illness, temporary or permanent disability, and death), damage, loss, claim, liability, or expense, of any kind, that I and/or my child(ren) may experience or incur in connection with my and/or my child(ren)'s entering the CVI Facilities or by participating in programs and services offered there, whether offered directly by CVI or by tenant or subcontractor of CVI (collectively, the **"Claims"**). On my behalf, and on behalf of my children, I hereby release and indemnify the CVI Parties, and each of them, from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto, and covenant not to sue the CVI Parties, or any of them, for any Claims. I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of the CVI Parties, or any of them, whether a COVID-19 infection occurs before, during, or after my entering the CVI Facilities for any purpose whatsoever.

I further consent, on behalf of myself and my child(ren), for CVI to take my/our temperature as a condition to entry into the CVI Facilities and further acknowledge and agree that CVI may deny access to the CVI Facilities if I and/or my child(ren) have an elevated temperature, as shown by the temperature test taken at the CVI Facilities.

I further represent that I and my child(ren) are feeling well today and that neither I nor my child(ren) have contracted COVID-19 or have any other flu-like symptoms including a cough, nasal congestion, loss of smell or loss of taste.

____
Signature of Visitor or Parent/Guardian **Date**

____
Print Name of Visitor or Parent/Guardian

____
Print Name(s) of CVI Program Participant(s)

Financial Policy

Patient Financial Agreement

Florence Maxwell Low Vision Clinic is committed to serving our patients with professionalism and caring and from our patients we expect the same commitment. This includes being on time for your appointment and calling to cancel an appointment if you can't make it. It also includes financial responsibility, like presenting your identification and insurance cards at every appointment and making your copay and deductible payments at the time of your office visit with cash, check or credit card.

Your responsibility is to provide us with accurate and complete information concerning your primary and secondary insurance medical benefits, including referral documents from other providers. Current identification and insurance benefit cards are to be presented at each office visit. As a courtesy, Florence Maxwell Low Vision Clinic will file your insurance claim for you. If you are a Medicare patient, we will bill Medicare and your secondary insurance for you.

I understand that my signature requests payment be made to pay my claim. My signature also authorizes the release of medical information necessary to pay my claim. I also understand that any amount not covered by medical insurance, after claim processing is my responsibility. Initials (_____)

If you do not have insurance, self-pay options and other funding may be available. Please speak with one of our staff to discuss payment options.

Patient Name:(Print)

____

Patient Signature:

____ Date: ____________

I have read, and I understand Florence Maxwell Low Vision Clinic's financial policies and I accept responsibility for the payment of any fees associated with my care.

Mississippi State University Release Form

Center for the Visually Imapired

Authorization to Release Information

Consumer's Name:

Date of Birth:

I hereby authorize Center for the Visually Impaired to release the following to:

Name: Mississippi State University – The National Research and Training Center on Blindness and Low Vision
Address: Mississippi State, MS 39762

the following information from the records pertaining to services received
Date of Service:

The information to be released are described or listed as: Name, Date of Birth, Contact information, services received

The records are required for the specific purpose of evaluating your experience with Project Independence

I understand that my authorization will remain effective from the date of my signature until, one year from the date signed

and that the information will be handled confidentially in compliance with all applicable state and federal laws.

I may revoke the authorization at any time by written, dated communication.

I have read and understand the nature of this release.

____

Signature of Consumer/Consumer's Designated Representative   Date

____

Witness   Date

The Georgia Client Assistance Program

A division of the Law Offices of Martin and Jones

Jennifer Page, Director
Stephanie Woods, Counselor/Advocate

Welcome to the Georgia Client Assistance Program
Thank you for visiting the Georgia Client Assistance Program (CAP). The CAP is for Rehabilitation clients and client applicants who are seeking or receiving services from a project, program or facility funded under the Rehabilitation Act.

What is the Client Assistance Program?
Client Assistance Programs are funded by the U. S. Department of Education in all states as part of grants for Vocational Rehabilitation of individuals with disabilities. The Georgia Vocational Rehabilitation Agency has privatized the management and operation of the Client Assistance Program to be administered by Martin and Jones. The Client Assistance Program helps people with disabilities who are seeking or receiving rehabilitation services by:

- **Providing information** about the federal Rehabilitation Act, including
  How you qualify
  How you pilot your own rehabilitation
  The purpose of the Rehabilitation Act
  Your rights under the Act
- **Assisting** individuals who have problems applying for or receiving services under the Act.
- **Teaching** you how to make requests
- **Referring** you to other agencies where helpful
- **Negotiating** for you
- **Mediating** disputes
- **Advocating** for you with the agency and others
- **Presenting** your requests to the agency
- **Obtaining** legal representation where we think it appropriate

What can the Client Assistance Program do for me?
If you have a problem with your rehabilitation program or application, the Client Assistance Program can assist you in many ways, including:
- Advising you of your rights
- Solving communication problems
- Teaching you how to make requests
- Referring you to other agencies where helpful
- Negotiating for you
- Mediating disputes
- Advocating for you with the agency and others
- Presenting your requests to the agency
- Obtaining legal representation where we think it appropriate

When and how do I contact the Client Assistance Program?
You may call the Client Assistance Program for any of the following reasons:

- You want to know what is required to qualify for rehabilitation services
- You believe you qualify for rehabilitation services but are not allowed to complete an application
- You disagree with any decision to deny, stop or delay services
- You cannot get a written decision on a request you have made
- You are not allowed enough choice in your rehabilitation program
- You have a disability-related problem, and do not know where to go to get help

Who runs the Client Assistance Program?
The Governor of Georgia has designated the Law Offices of Martin and Jones to operate the client assistance program. The staff of the Client Assistance Program includes:

Jennifer Page, Director
Stephanie Woods, Counselor/Advocate

You may reach the Client Assistance Program by a toll-free telephone call state wide to:
(800) 822-9727

In the Atlanta area, call
(404) 373-2040 (voice/TTD) (or via Georgia Relay Service 800 255-0135)

Our fax number is
(404) 373-4110

Our address is
123 N. McDonough Street
Decatur, Georgia 30030