

Last Name: \_\_\_\_\_ First \_\_\_\_\_ DOB \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION:** I, the undersigned, authorize the release of my medical information to my insurance company and the assignment of benefits from my insurance company to The Eye Center.

Patient/Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

**PATIENT RESPONSIBILITY FOR PAYMENTS:** In being accepted as a patient of The Eye Center, I realize that I am responsible for all charges incurred. Payment for services is due the day services are provided (unless prior arrangements are made in writing.) I understand that The Eye Center will file my insurance for me, but I am responsible for deductibles, co-payments, uncovered services, and claims denied by my insurance company.

Patient/Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

**RECEIPT OF NOTICE OF PRIVACY PRACTICES:** I have received a copy of the Notice of Privacy Practices that describes how my health information is used and shared. I understand that The Eye Center has the right to change this notice at any time. I may obtain a current copy by contacting The Eye Center.

Patient/Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_