AUTHORIZATION FOR RELEASE OF INFORMATION

I HEREBY AUTHORIZE EYECARE SPECIALISTS to release information requested by my insurance carrier and/or Worker's Compensation carrier. Additionally, I authorize EYECARE SPECIALISTS to release information to any hospital or physician I may be referred to by this health care provider.

Date: _____ Signature:_____

Relationship to Patient:_____

ASSIGNMENT OF BENEFITS

I HEREBY AUTHROIZE assignment and payment directly to EYECARE SPECIALISTS of any major medical benefits and/or Medicare due me. I understand that insurance may not and that Medicare does not pay one hundred percent (100%) of the medical charges.

I HEREBY ACKNOWLEDGE and agree to pay any and all charges that exceed or that are not covered by insurance and/or Medicare, including any deductible. I also acknowledge that I am responsible for reasonable interest, collection fees, attorney fees, and/or court costs incurred in connection with any attempt to collect amounts I may owe EYECARE SPECIALISTS

Date: _____ Signature: _____

Relationship to Patient: _____

PAYMENT

Payment is due at the time services are provided. Every effort is made to bill most insurances. Your cooperation is essential – please provide correct and current copies of all vision and medical insurance cards that we are providers for. If there has been a change in your insurance, address, telephone number, and/or employment since your last visit, please notify the receptionist prior to being seen by the health care provider. If after thirty (30) days payment is not paid in full, a finance charge of ten percent (10%) per annum will be charged to the balance of the account. If special payment arrangements are necessary, please speak with the office manager prior to being seen.

EMAIL ACKNOWLEDGMENT

By providing your email address with our office, we promise to only contact you for medical purposes. Examples of such are newsletters about our products and latest medical treatments, messages concerning your glasses, and/or messages concerning your contacts.

Email address: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have been provided a copy of EYECARE SPECIALISTS Notice of Privacy Practices.

Date: _____ Signature: _____

Relationship to Patient: _____

OFFICE USE ONLY

Date acknowledgment received: _____ -OR-

Reason acknowledgment was not obtained: