



Please Sign Both the Privacy Practices & the Payment Information

Notice of Privacy Practice

I acknowledge that I have read or have had the opportunity to read the Notice of Privacy Practices (available at the front desk).

Patient Name (please print): _____ **Date:** _____

Signature of Patient or Guardian:

Payment Information

Payment Information – Please read and sign below. Thank you.

1. I authorize you to bill my insurance for any applicable services or products.
2. I understand that payments for non-insured services are **due the same day services are rendered .**
3. I understand if I have not met my health insurance deductible and I'm receiving medical eyecare that **50% of the bill is due today,** and any balance remaining after being processed through insurance will be billed to me.

Signature of Patient or Guardian:

_____ **Date:** _____

We are glad to answer any questions regarding your insurance benefits. Thanks!