I hereby authorize Eye Care Physicians & Surgeons, PC to apply benefits on my behalf for covered Services rendered.

Patient's Signature: \_\_\_\_\_\_ Date : \_\_\_\_\_

I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information including material information for this or any related claim to my insurance carrier. I assign to Eye Care Physicians & Surgeons, PC any and all benefits incurred for the services provided by them and any other further services. I understand I am financially responsible for charges not covered by my insurance. This includes payment of any deductible amount and/or any unpaid balance after payment by my insurance carrier(s). I accept responsibility for payment in full service provided by Eye Care Physicians & Surgeon, PC not paid by my insurance within (30) days of receiving services. In the event I do not meet my financial responsibility with Eye Care Physicians & Surgeons, PC, I agree to pay cost for collection, including attorney's fees at 50% plus court and interest.

HMO OR PPO PATIENTS

•••	NO OKTTO TATILITIES
If any services are performed in our office and pri co-pays that are generated from their out of netw	or authorizations have been obtained, I am responsible for any deductions or ork benefits.
Patient's Signature:	Date :
Gen	eral Informed Consent
outpatient treatment from professionals at Eye Catherapy services, diagnostic tests, medications an judgment. I understand that all services are availar creed, national origin, religion, or handicap. At an event of an emergency, I authorize Eye Care Physt treatment as may be deemed advisable under the billing, treatment and healthcare operations which of my insurance carriers the review the review of	eons, PC to carry out all procedures ordered by my physician. I request are Physicians & Surgeons, PC and consent to all: diagnostic evaluations, d/or treatments that are ordered or preferred by these professionals in their ble and will be provided to all individuals regardless of age, sex, race, color, y time while on the premises of Eye Care Physicians & Surgeon, PC in the cians & Surgeons, PC or their employees to provide or obtain such medical circumstances. I consent to the release of my records for the purpose of a may include but are not limited to review by the authorized representatives my records or any necessary audits within Eye Care Physicians & Surgeons, or referral sources. I understand that my records are the property of Eye Care
Patient's Signature:	Date :
PRAC I was given the Notice of Privacy Practices along	TICE INFORMATION/HIPAA with the Practice Information Sheet.
Patient's Signature:	Date :
Eye Care Physicians & Surgeons, PC  Witness:	Date: