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

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.

Patient's Signature: _____ Date : _____

HMO OR PPO PATIENTS

If any services are performed in our office and prior authorizations have been obtained, I am responsible for any deductions or co-pays that are generated from their out of network benefits.

Patient's Signature: _____ Date : _____

General Informed Consent

I authorize the staff of Eye Care Physicians & Surgeons, PC to carry out all procedures ordered by my physician. I request outpatient treatment from professionals at Eye Care Physicians & Surgeons, PC and consent to all: diagnostic evaluations, therapy services, diagnostic tests, medications and/or treatments that are ordered or preferred by these professionals in their judgment. I understand that all services are available and will be provided to all individuals regardless of age, sex, race, color, creed, national origin, religion, or handicap. At any time while on the premises of Eye Care Physicians & Surgeon, PC in the event of an emergency, I authorize Eye Care Physicians & Surgeons, PC or their employees to provide or obtain such medical treatment as may be deemed advisable under the circumstances. I consent to the release of my records for the purpose of billing, treatment and healthcare operations which may include but are not limited to review by the authorized representatives of my insurance carriers the review the review of my records or any necessary audits within Eye Care Physicians & Surgeons, PC, and for summary information to be released to referral sources. I understand that my records are the property of Eye Care Physicians & Surgeons, PC.

P**atient's Signature: _____ Date : _____**

PRACTICE INFORMATION/HIPAA

I was given the Notice of Privacy Practices along with the Practice Information Sheet.

Patient's Signature: _____ Date : _____

Eye Care Physicians & Surgeons, PC Date: _____

Witness: _____