

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 **Eye Center South**.

Patient/Parent/Guardian Signature: _____

Date: _____

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

Patient/Parent/Guardian Signature: _____

Date: _____

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 South has the right to change this notice at any time. I may obtain a current copy by contacting the doctor's office or by visiting their web site at www.eyecentersouth.com

Patient/Parent/Guardian Signature: _____

Date: _____