Eye Center South

2020 Cattlemen Rd. #500

Sarasota, FL 34237

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 or Guardian Signature:____

Date:____

PATIENT RESPONSIBILITY FOR PAYMENTS: In being accepted as a patient of **EYE CENTER SOUTH**, I realize I am responsible for all charges incurred. Payment is due at time 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 or Gaurdian 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 **EYE CENTER SOUTH** has the right to change this notice at anytime. I may obtain a current copy by contacting the doctor's office or visiting **www.eyecentersouth.com**.

Patient/Parent or Gaurdian Signature:____

Date:____