Statement of Accuracy:

All Statements on the patient intake form are accurate and true to the best of my knowledge. I understand that treatments will be based on the information provided herein. If I willingly withhold knowledge from my treating physician, I accept full liability from any consequences arising there from.

Financial Responsibility:

Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made.

Your medical health coverage is a contract between you and your insurance company. Healthy Eyes will file In-Network medical and vision insurance claims. Insurance company co-payments and deductibles are due at time of service. Patients with Out-of-Network insurance are responsible for payment in full at time of service. A billing statement will be prepared for you to file with your insurance company. By signing below, you give your consent for Healthy Eyes to file a medical or vision claim to your carrier, and you agree that all charges deemed "patient responsibility" on the Explanation of Benefits will be promptly paid.

You understand that should this account be referred to an agency or an attorney for collection, you will be responsible for all collection costs, attorney's fees, court costs and interest accrued.

Acknowledgement of Privacy Policy:

Your information is protected by our privacy policy. Signing below indicates that you have read the Healthy Eyes "Notice of Privacy Practices" and authorize consent to use and disclose your protected health care information for the purposes of treatment, payment and health care operations.

PLEASE LIST ANY INDIVIDUALS OTHER THAN YOURSELF THAT WE MAY DISCLOSE INFORMATION TO BELOW

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If you are signing for a minor, you attest that you have legal authority to make medical decisions for the minor.

I have read and understand all of the above and have agreed to these statements.

_____ _____

Patient's (or Legal Guardian's) Signature **Date**