EYES ON LAKE NORMAN
OPTOMETRY

AUTHORIZATION TO RELEASE INFORMATION: **I authorize Eyes on Lake Norman Optometry to release any medical or incidental information that may be necessary for medical benefit, payment and healthcare operations. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration, and Worker's Compensation.**

CONSENT FOR TREATMENT: I hereby authorize Eyes on Lake Norman Optometry to administer diagnostic and medical procedures as may be necessary for proper health care.

OFFICE POLICY ON PAYMENT: I understand that I am solely responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, copay or any other balance not paid by my insurance company. I authorize insurance benefits to be paid directly to the provider.

VISION PLAN COVERGAE: I understand that only one vision plan may be used for exam/materials per visit-per patient.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES: I have received and/or been offered a copy of the Notice of Privacy Practices for the above named practice.

SIGNATURE:_____DATE:_____