I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS AND AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE EYE CENTER OF INDIANA.

I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES PROVIDED BY THE EYE CENTER OF INDIANA TO ME OR TO MY DEPENDENTS.

A CHARGE OF $25 WILL BE MADE FOR NSF OR RETURNED CHECKS.

A $50 CHARGE WILL BE MADE AFTER A SECOND NO SHOW APPOINTMENT.

IF A THIRD PARTY IS INVOLVED TO RESOLVE PAYMENT FOR SERVICES PROVIDED BY THE EYE CENTER OF INDIANA, I AGREE TO BE RESPONSIBLE FOR ALL CHARGES INCURRED.

YOUR MEDICAL INFORMATION IS PERSONAL TO YOU, AND BY LAW THE EYE CENTER OF INDIANA IS REQUIRED TO MAKE SURE THAT IT IS KEPT PRIVATE.

ON OCCASION A FAMILY MEMBER, FRIEND, OR CAREGIVER MAY CONTACT THE EYE CENTER OF INDIANA TO INQUIRE ABOUT YOUR MEDICAL INFORMATION. PLEASE LIST THOSE INDIVIDUALS TO WHOM THE INFORMATION MAY BE DISCLOSED.

NAME(S) RELATIONSHIP(S)

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Signature: ____________________________________ Date: ____________________