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WESTON EYE CENTER

AN NVISION COMPANY

Jon-Marc Weston, MD Steven F. Tronnes, OD Greg M. Valle, OD

THE FORMS IN YOUR PACKET CONTAIN ALL THE NECESSARY INFORMATION FOR YOUR SCHEDULED EXAMINATION. PLEASE INITIAL AND SIGN ALL AREAS BELOW:

1. Please initial each statement

_____ I have received the "Signature on File, Assignment of Benefits & Financial Agreement". I give my permission to bill my insurance(s).

_____ I have received the HIPAA" Notice of Privacy Practices".

_____ I have received Weston Eye Center's "Consent for Dilating Eye Drops".

_____ I have received Weston Eye Center's "Office Payment Policies".

_____ I have been notified that my examination information in is electronic form and web registration is required.

2. I give my permission for affiliates of Weston Eye Center to speak to the following person(s) regarding my care:

Name:_____Relationship:_____

Name:_____Relationship:_____

3. If you are under the age of 65 would you like this examination billed through your:

□Medical Insurance □Vision Insurance

4. Emergency Contact:

Name:_____Phone Number:_____

Print Name:_____

Patient Signature: Date: