INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/ or Medicare benefits, and I authorize payment of these benefits to Central Ohio Eye Care, LLC dba Grove City Vision Center on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer of agency shown, and authorizes my doctor to act as my agent, as above. I assume financial responsibility for any copays, deductibles not yet met and/or in the case that my insurance company denies the claim.

_____ _____

Lifetime Patient Signature Date

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have been offered or received a copy of Central Ohio Eye Care LLC's Notice of Privacy Practices.

Patient Name:_____

Signature:_____ Date:_____