FINANCIAL RESPONSIBILITY WAIVER OF LIABILITY - SIGHT EYE CLINIC, P.C.

I understand that some services such as refractions, routine eye examinations, screening examinations and charges for contact lenses and glasses provided to me may not be covered under Medicare and insurance guidelines. I have read and understand this statement and choose to accept those services.

I understand and accept full responsibility for all charges, whether or not paid by Medicare, private insurance, or any other insurance plan. In the event this account is assigned to collection, I agree to pay a one-time collection fee of 50% of the bill.

I authorize and assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Sight Eye Clinic, P.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I further authorize said assignee to release all information necessary to secure payment.

X_____ **X**_____

Signature of Patient Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

X_____ **X**_____

Signed Date

_____ _____

Witness Date

Private Party Billing and Medical Information Release

I give permission for Sight Eye Clinic, P.C. to release my (or my child's) medical and /or billing information to the following person(s):

1._____

2._____

3._____

X_____ **X**_____

Signed Date