Lifetime 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 with payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Jeffrey S. Nevitt, OD 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 or agency shown, and authorizes my doctor to act as my agent, as above.

If my insurance denies the services billed because benefits were not eligible, I will accept full responsibility for payment in full.

_____ _____

Patient's/ Legal Guardian's Signature *Date*

Pacific Eye Clinic's Notice of Communication Practices:

By my signature below I acknowledge receipt of the Notice of communication practices

By providing a contact number(s) or email, I expressly consent to receiving communications from the provider(s), its staff/contractors and others, at any numbers I provide or that are later acquired for me. These parties may use this information to contact me by live agent, voicemail, text message, using auto dialer or other computer assisted technology, pre-recorded message(s), or by any other form of electronic communication, including email at any email address I provide, for any purpose

_____ _____

Signature *Date*

Pacific Eye Clinic's Notice of Privacy Practices

By my signature below I acknowledge receipt of the Notice of Privacy Practices:

_____ _____

Signature *Date*

By signing below, I give Pacific Eye Clinic permission to leave a message when contacting me by phone, email, or text message and to release medical information to the following:

- **Spouse:** _____
- **Parents:** _____
- **Children:** _____
- **Care Giver :** _____
- **Other:** _____

_____ _____

Signature *Date*