SIGNATURE ON FILE

I hereby attest that I have provided *Village Eye Care, PC* a **current and valid** Health Insurance ID card, and my insurance premiums are paid in full at the time services are rendered. _____

Presenting valid health insurance information is no guarantee of payment by said health insurance company. Please refer to your health/vision insurance coverage guidelines provided by your insurance company. _____

I hereby authorize payment of my medical and/or vision insurance benefits to *Village Eye Care, P.C.*

_____

I understand I am financially responsible for any charges if not paid by said insurance. If co-payments and/or deductibles/co-insurance are designated by my insurance company or health plan, I agree to pay them to *Village Eye Care, P.C within 30 days of receiving an invoice.* _____

- **We require a 24 hour notice of cancellation of all scheduled appointments. There will be a $30 charge to your account for any failed or cancelled appointments without a prior 24 hour notice.**

I authorize *Village Eye Care, P.C.* to release medical information to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

_____ _____

PATIENT / Parent / Guardian SIGNATURE *PRINT*

_____ _____

Relationship to Patient: *DATE*

****

My signature below indicates I have reviewed the above and my initials are still valid.

CHECK BELOW IF USING CARE CREDIT ?

_____ **Date:** _____ **YES: __ / NO __**

_____ **Date:** _____ **YES: __ / NO __**

_____ **Date:** _____ **YES: __ / NO __**

_____ **Date:** _____ **YES: __ / NO __**

_____ **Date:** _____ **YES: __ / NO __**