Acknowledgment of Privacy practices: We have copies of central vision center's privacy policy available to you. If you would like a copy request one at front desk. It is also available on-line at centralvisioncenter.com. Please sign that you understand that this policy is available to you.

*******Signature_____Date:_____

Permission to get medication information from pharmacy or primary care provider: I give my permission to find out a list of my current medications and/or diabetic lab reports from my pharmacy or my doctor:

*******Signature_____Date:_____

Insurance Information and Authorization: Name of insurance:_____

Insured's ID no:_____Insured's employer:_____Group number:_____

Name of subscriber of insurance plan:_____ Date of birth of subscriber:_____

Plan name:_____ Relationship of patient to subscriber: circle one Spouse Child Other

Address of subscriber:_____

Is this insurance for (circle one) major medical vision plan **Is this related to an accident?** Y or N **work- related?** Y or N

PLEASE PROVIDE A COPY OF THE INSURANCE CARD TO OUR STAFF

Insurance Authorization:

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government or insurance company benefits either to myself or to the party who accepts assignment. I authorize payment of medical or vision benefits to Dr. Steve Shoup, Dr. Cynthia Shoup and/or Central Vision Center for services rendered to the patient listed on the other side of this form.

*******Signature:_____Date:_____

FINANCIAL RESPONSIBILITY

Patient, Parent or Guardian: I am financially responsible for all charges, co-pays and deductibles not covered by insurance. I know that I am responsible for providing accurate and current information for billing purposes. Amounts owed by patients are determined by the insurance company. Although we try to get accurate information from the insurance plan at the time of the exam, the amount quoted by our staff may not reflect your actual amount owed until we hear from your insurance company.

*******Signature:_____Date:_____