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Receipt of Notice of Privacy Practice

I acknowledge that I have received a copy of MD Eyecare LLC's notice of privacy practices. I understand that if I have any other questions of concerns I should speak to Dr. Duncan or one of the staff members.

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Signature *Date*

AUTHORIZATION TO COLLECT FROM PATIENT'S INSURANCE COMPANY

I request the direct payment of authorized medical benefits (including Medicare, Medigap, major medical benefits) be made to MD Eyecare, LLC for any services furnished me by these physicians. I authorize any holder of medical information about me to release this information to my insurance carrier (or intermediaries), to the Health Care Financing Administration and its agents, to my attorney, or to another physician's office. Also, I permit a copy of this authorization to be used in place of the original copy. This assignment will remain in effect until I revoke, in writing, this authorization.

Further, I understand that because these services were performed for me or for my legal dependent, I am financially responsible for all charges whether or not paid by the insurance carrier.

____________________________ ______________________

Signature *Date*