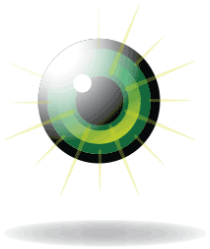

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Insurance Disclaimer: A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service.

Beneficiary Agreement: I understand that my health insurance company may deny or revoke payment for the services received. If my health insurance company denies or revokes payment, I agree to be personally and fully responsible for payment. I also understand if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

_____
Patient's Name

_____ Date: _____
Patient/Guardian Signature

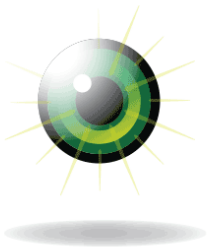
Permission to Discuss Medical Information

According to HIPPA laws, all medical records are confidential. We require written authorization to
release medical and billing information to anyone other than the patient. By signing the authorization below, you are giving the Heaston and Thompson Vision Clinic permission to discuss the information contained in your health record with another individual.

I, _____, give the Optometrists and staff of the Heaston and Thompson Vision Clinic permission to discuss my medical and billing information with the following people:

_____
_____
_____
_____

Signature: _____ Date: _____
Permission expiry date:_____



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