LAPORTE VISION CENTER
1105 S. BROADWAY
LAPORTE, TX 77571
(281) 471-6546

Effective Date: 04/14/2003

I acknowledge that I received a copy of LaPorte Vision Centers' Notice of Privacy Practices.

Patient Name____

Signature______________________________________ Date________________

I agree to be notified by LaPorte Vision Center, its' doctors, and staff members concerning my care by the following (**please check all that apply**):

______ Mail
______ Home Phone (_____) ______-________
______ Work Phone (_____) ______-________
______ Cell Phone (_____) ______-________
______ Leave message on machine or voice mail
______ Leave message with person answering phone
______ All of the above

Please indicate any individuals to whom your health information may be released:

_____ mother	_____ father	_____ spouse
_____ stepmother	_____ stepfather	
_____ grandmother	_____ grandfather	
_____ sister	_____ brother	
_____ daughter	_____ son	
_____ legal guardian	other______________________________________	

Assignment of Benefits: I hereby authorize payment directly to LaPorte Vision Center/Dr. Deborah Bernay for any and all medical/routine vision benefits applicable and otherwise payable to me. I also understand that the payment for services being billed to my insurance company on my behalf is my responsibility whether or not my insurance company covers the services.

Signature__________________________________

IF PATIENT IS UNDER 18: I hereby give my permission for _____________________ to be treated by Dr. Deborah Bernay. **THIS MUST BE SIGNED IN ORDER TO FILE YOUR INSURANCE LIABILITY CLAIM.**

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Parent/Guardian Signature