I authorize Barrington Eye Care, PC to bill my insurance, HMO, vision care plan, or other responsible party for examination and testing. I understand I am responsible for any copays or charges not covered by my insurance. I understand that any insurance information not presented on the day of the visit will not be processed.

I acknowledge that I will be assessed a fee in the amount of $40 for any No-Show Appointments. I understand that I must provide a 24 hour notification of cancellation / rescheduling to avoid the fee.

Per the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I acknowledge that protected health information may be disclosed for treatment, payment or sent to other healthcare providers (ex: PCP, Cataract Surgeon, LASIK etc) for co-management (if applicable).

Patient Name / Guardian (Print) ____

Signature ____ Date _______________