Assignment and Release

I certify that I, and/ or my dependents have insurance coverage with _____ and assign directly to Dr. Shrayman all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Name X _____ Date _____

Notice of Privacy Practices

Dr. Shrayman is required by law to protect certain aspects of your health care information and to provide you with a Notice of Privacy Practices. The notices describes our privacy practices, your legal rights and lets you know how Dr. Shrayman is permitted to:

- Use and disclose PHI about you
- How you can access and copy that information
- How you may request amendment of that information
- How you may request restrictions on our use and disclosure of your protected health information

The notice is available for you at the front desk. Please sign that you have received and reviewed its contents.

Name X _____ Date _____

Consent for Dilation

A comprehensive eye examination includes papillary dilation in order to better view the back of the eye (the retina). Dilation requires instilling drops into the eyes which will dilate the pupils, causing sensitivity to light and near vision blur that will last for several hours. You may do this today, reschedule for a time that is more convenient for you, or decline to have the procedure done. There is no extra charge for this procedure.

I have been informed of the risks/benefits of dilation and **DO / DO NOT** want a dilated eye exam today.

Name X _____ Date _____