I hereby authorize Loudoun Eye Associates, pLLC to release or exchange any information necessary to process my insurance claims. I will receive services with the understanding that in the event my coverage is not effective, I will be billed by the service provider and held responsible for services rendered. Furthermore, I understand what my benefits are and that there may be additional charges beyond the coverage benefits. I have reviewed the Notice of Privacy Practices for Loudoun Eye Associates, pLLC, and a copy of the notice has been made available for me at my request.

Print Name of Patient: _____

If patient is a minor, Print Name of Parent or Guardian: _____

Date: _____

_____ _____

Client Signature Date