Eye Surgical Associates, 2664 Hartford Hwy, Dothan, AL 36305

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize the doctor to release any medical information including diagnosis, x-rays, test results, reports, and records pertaining to any treatment or examination rendered to me. I understand this medical information may be used for any of the following procedures: diagnostic, insurance, legal, and at times when the doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand any person(s), including referring and/or medical doctor, and when Workmen's Compensation is involved, that receive these medical records will not release any of the medical information obtained by this authorization to any person or organization without further authorization signed by me for the release of information.

NOTICE OF PRIVACY PRACTICES

I acknowledge I have received a copy of Eye Surgical Associates "Notice of Privacy Practices". This notice describes how Eye Surgical Associates may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

AUTHORIZATION FOR PAYMENT

Authorization: I authorize payment of my medical benefits to Eye Surgical Associates, PC. I also authorize the release of any information necessary to process my claims(s).

Agreement to pay: I understand if my account becomes delinquent, it will be placed with Prim & Mendheim, LLC. Further, I agree to the following terms regarding any outstanding balance that I owe. (1) I will incur interest at the rate of 1 ½ percent per month (18% PER ANNUM). (2) I agree and hereby consent I will be responsible for reasonable collection costs and the cost of court incurred by Eye Surgical Associates, PC, in the collection of the same, whether such outstanding balance is satisfied prior to, after initiation of lawsuit, and/or legal proceeding surrounding the outstanding balance and debt, and fees and cost thereon, shall be initiated and litigated in a court of law. I affirmatively acknowledge I have read the same before signing. Furthermore, I agree if a cell phone number has been provided I can be contacted regarding my balance on said cell phone. Additionally, if I reside in Florida I agree to waive my rights to any exemption that would prohibit a wage garnishment should same become necessary to secure payment of any outstanding balance. I also agree that at any time if my balance has not been paid according to policy, I understand my credit history will be investigated and thoroughly reviewed. By signing below, I consent to the terms contained herein and affirmatively acknowledge I have read the same before signing.

_____ _____

Patient/Guardian Signature Date