Ries Eyecare

www.rieseyecare.com

Name_____ **Date _____**

Name of Guardian/Authorized Representative _____ Relationship_____

Contact Lens Agreement

By signing below, I acknowledge that I have reviewed the Contact Lens Agreement and understand that a copy is available to keep if I so choose.

Lifetime Signature of Patient, Guardian, or Authorized Representative _____

Insurance Policy

By signing below, I acknowledge that I have reviewed the Insurance Policy and understand that a copy is available to keep if I so choose.

Lifetime Signature of Patient, Guardian, or Authorized Representative _____

Financial Policy

By signing below, I acknowledge that I have reviewed the Financial Policy and understand that a copy is available to keep if I so choose.

Lifetime Signature of Patient, Guardian, or Authorized Representative _____

HIPAA Compliance Agreement

By signing below, I acknowledge that I have reviewed the Privacy Policy and understand that a copy is available to keep if I so choose.

Lifetime Signature of Patient, Guardian, or Authorized Representative _____

Authorization to Release Information

By signing below, I authorize you to discuss my private medical information with those listed below.

Name of Person	Relationship to Patient
_____	_____
_____	_____
_____	_____

Name of Physician

_____

Name of Pharmacy	Location of Pharmacy
_____	_____

Lifetime Signature of Patient, Guardian, or Authorized Representative _____