EVERY EYE CARE

Dr. Terrence Roberts, O.D.

PLEASE READ AND SIGN

By signing below I certify that I have received and reviewed the Notice of Privacy Practices as required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1966 (HIPPAA) and that all of my questions have been answered to my satisfaction.

PRINT NAME:_____

Parent or Guardian (if under 18):_____

Signature:_____

Date:_____

PLEASE READ AND SIGN

We will be happy to file the insurance you present at the time of service. If at a later date you find that you have another of different insurance; it will be your responsibility to file that insurance. We will provide you with a statement in order for you to file.

PRINT NAME:_____

Parent or Guardian (if under 18):_____

Signature:_____