

**EyeCare Consultants
PATIENT INFORMATION SHEET (Continued)**

INSURANCE INFORMATION

Name of Primary Insurance:				
Name of Subscriber:		Name of Subscriber's Employer:		
Relationship to Patient:	Self	Spouse	Child	Other:
Name of Secondary Insurance:				
Name of Subscriber:		Name of Subscriber's Employer:		
Relationship to Patient:	Self	Spouse	Child	Other:
Name of Other Insurance:				
Name of Subscriber:		Name of Subscriber's Employer:		
Relationship to Patient:	Self	Spouse	Child	Other:

NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received the Notice of Privacy Practices form from EyeCare Consultants, LLC.

Patient Signature

Date