COMMERCE VISION GROUP, LLC

PATIENT PORTAL ACCESS CONSENT		
Please check the box below and sign the agreement should you wish	to participate:	
□ Yes, sign me up!		
□ No, I do not wish to participate.		
Print Name	Email Address	
Patient Signature	Date	
CONTACT LENS ASSESSMENT/EVALUATION CONSENT		
The undersigned hereby acknowledges understanding the risks, bene-	fits and stated policies.	
The undersigned never assure wronger understanding the risks, cent	ino, and stated pointers.	
Patient or Parent/Legal Guardian Signature	Date	
Print Patient Name		
PATIENT FINANCIAL POLICY STATEMENT		
I have read the Patient Financial Policy and agree to abide its terms.		
That of total the Tations I maile and Total and agree to do not to terms.		
D. Charles	Data a CD inth	
Patient Name	Date of Birth	
Patient or Parent/Legal Guardian Signature	Date	
HIPPA ACKNOWLEGEMENT AND CONSENT FOR USE AN HEATLH INFORMATION	D DISCLOSURE OF PRO	TECTI
Patient Name	Date	
Printed Name	Witness Signature	-
FITHER INMITE	w illiess Signature	