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, benefits, and stated policies.

_____ _____

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.

_____ _____

Patient Name Date of Birth

_____ _____

Patient or Parent/Legal Guardian Signature Date

HIPPA ACKNOWLEGEMENT AND CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEATLH INFORMATION

_____ _____

Patient Name Date

_____ _____

Printed Name Witness Signature