DATE:_____

I _____DO HEREBY AUTHORIZE THAT I DO NOT HAVE ANY INSURANCE THAT I WOULD LIKE TO FILE AT THIS TIME VISION OR MEDICAL .

SIGNATURE

_____

EYESIGHT ASSOCIATES IDENTITY THEFT PREVENTION POLICY

Effective May 1, 2009, the staff of Eyesight Associates will be required under the Federal Trade Commission (FTC) to verify your identity. Upon time of patient registration / check in, you will be requested to provide either a Driver's license or other photo ID, current health insurance card(s), and proof of address such as a utility bill if the photo ID does not show your current address. The parent or legal guardian of a minor patient (under the age of 18) should bring the above stated information.

Eyesight Associates reserves the right to decline services if you fail to provide the necessary information. This is a requirement by the FTC to protect your identity. Eyesight Associates is bound to protect all sensitive patient health information under the HIPAA security standards.

I hereby acknowledge I have provided Eyesight Associates with the correct proof of identification. By signing this form, I certify that I have read and fully understand this policy.

_____ _____

Date **Patient Signature**

_____

Parent or Legal Guardian Signature