BALTIMORE WASHINGTON EYE CENTER

Permission to Treat

I, the undersigned ____ parent ____ legal guardian, do hereby give the Baltimore Washington Eye Center permission to treat _____, my ____ child ____ ward, for any vision or other problems related to his/her eyes using whatever ophthalmic treatments that Baltimore Washington Eye Center doctors deems medically necessary. This may include tests that are needed for the diagnosis of the condition for which the patient is being seen. This permission is valid for one year from this date, or until _____, ____, which date is less than one year from the date below.

I also authorize the following individuals to access my ____ child's ____ ward's medical records:

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

I further authorize the release of my ____ child's ____ ward's medical record information for purposes of obtaining payment or any further treatment necessary.

Print Name: _____ Date: _____

Signature of Parent or Guardian: _____

Financial Responsibility

_____ shall be financially responsible for any charges related to this visit, and any subsequent visits, until the expiration date specified above. This will be accomplished by billing the insurance plan or individual as specified on this form.

(Continued on back of page)

EITHER: ____ Bill my health insurance plan.

INSURANCE COMPANY: _____

INSURANCE COMPANY CLAIMS ADDRESS: _____

CITY _____ STATE _____ ZIP CODE _____

IDENTIFICATION NUMBER: _____ GROUP NUMBER: _____

INSURED'S NAME _____ RELATIONSHIP TO PATIENT _____

SIGNATURE OF INSURED: _____ DATE: _____

OR: ____ Bill the following individual:

PRINT NAME: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ APT # _____

CITY: _____ STATE: _____ ZIP CODE: _____

SIGNATURE OF RESPONSIBLE PARTY: _____

DATE: _____