CONSENT FOR TREATMENT

I HEREBY AUTHORIZE East Valley Ophthalmology, Ltd. to examine and treat me, or the individual for whom I am responsible.

During the course of diagnosis or treatment, eye drops may be used to dilate the pupils. These drops may cause temporary blurred vision and glare. Driving an automobile, or operating machinery, is not advised until the effects of the drops have worn off.

I authorize East Valley Ophthalmology, Ltd. to release information acquired in the course of my examination and treatment to my insurance carriers.

I further understand that I have primary responsibility for payment of my charges.

X _____

Signature of Patient (or guardian)

FOR OUR MEDICARE PATIENTS

After you are seen by the doctor, East Valley Ophthalmology, Ltd. will submit a completed insurance form to Medicare. Their guidelines permit us to obtain a one-time signature that is valid for this and future visits to our office. By signing below, the notation "SIGNATURE ON FILE" will appear *in lieu* of your signature on all Medicare forms submitted for you by our office.

X _____

Signature of Medicare Beneficiary