Jessica A. Nisewonger, O.D., LLC

798 Southpark Blvd., Suite 24
Colonial Heights, VA 23834
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Consent of Treatment, Billing, and Notice of Privacy Practices

1. I, the undersigned, authorize Jessica A. Nisewonger, O.D., LLC (Family Vision Care) to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such eye care to third party payers and other health practitioners involved in my care. I authorize and request my insurance company or vision plan to pay directly to Jessica A. Nisewonger, O.D., LLC all benefits otherwise payable to me for services rendered and/or materials provided. I understand that my vision or medical insurance carrier may pay less than the actual bill for services. In the event it becomes necessary to collect a balance through litigation or a collection agency, I agree to pay all collection fees and attorney's fees incurred. I further authorize the use of this signature on all insurance submissions.

2. I understand that Jessica A. Nisewonger, O.D., LLC (Family Vision Care) will bill services rendered and/or materials provided to my vision plan and/or medical insurance plan. The appropriate plan to be billed is dependent on the entering complaint, the diagnosis, and the presence of any preexisting medical conditions. I understand that I will be informed of which plan will be billed, and I understand that I am responsible for the copays and/or deductibles that apply to that plan.

3. I acknowledge that I have been provided with a copy of the Notice of Privacy Practices of Jessica A. Nisewonger, O.D., LLC (Family Vision Care), effective 12/15/2015.

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Printed name of Patient Date

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Signature of Patient or Parent/Guardian