NORTHERN VALLEY
Eye Care INC.

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128 Fisher Pond Road
St. Albans, VT 05478

Steven J. St. Marie, O.D.
Laura L. Werner, O.D.

Consent to Treat & Guarantor

I, the undersigned, agree to be the responsible party for the patient identified below (the "Patient").

I understand and agree that by signing this form, I will be responsible for the payment of all costs for services and goods provided by Northern Valley Eyecare, Inc. (NVE) to the Patient, and that such payment is due payable at the time services are rendered and/or goods are provided. In the event that NVE bills the Patient's insurance, any copays or non-covered services are also my responsibility. I understand that finance charges may be added to my account. If I default on payment of this account, I realize I may be sent to a collection agency and my credit rating may be affected.

I give my permission for my son/daughter to receive eye care by the staff and doctors at Northern Valley Eye Care, Inc. including but not limited to diagnostic eye drops and drops that dilate the pupils, emergency care, office visits, management of medical prescriptions, eyeglasses, contact lenses.

I understand that it is my responsibility to advise NVE of any changes in the information contained on this form.

Patient: _____ Date of Birth: _____

Financially Responsible Party Information:

Parent or Responsible Party: _____ Date: _____

Date of Birth _____ Social Security No: _____

Street _____

City _____ State _____ Zip _____

Home Telephone _____ Work Telephone _____

Cell Telephone _____ email Address _____

In the event I no longer wish to be responsible for the account listed above, I understand I must notify Northern Valley Eyecare, Inc. in writing and account balances must be paid in full before I am released as the financially responsible party.

Signature: Date:

_____ _____