

**MANHATTAN VISION ASSOCIATES**  
**160 East 56 Street, Suite 300**  
**New York, NY 10022**  
**212-688-4277**

**Date:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**I understand that a portion of my comprehensive eye exam will be billed to my medical insurance (e.g. diagnostic imagining and testing for ocular disease such as glaucoma, cataract, etc.)**

**With the full understanding of the above, I consent to being responsible for co-payments, co-insurances and/or yearly deductibles that I have not met.**

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**Patient Signature**