SAULT VISION CLINIC P.C.

CONSENT TO TREATMENT

By my signature below, I do hereby voluntarily consent to treatment by optometrist of the practice for an eye exam and to any related diagnostic procedures and treatments as necessary in the judgement of the optometrist. I acknowledge that eye exams are not always routine in nature, and at the discretion of my optometrist, my medical insurance may be billed accordingly.

Signed: _____

Date: _____