Signature on File Form

~RESPONSIBILITY STATEMENT~

Your insurance is a method for you to receive reimbursement for fees you have paid to the optometrist for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances for percentages based on your contract with them not with our office. It is your responsibility to pay at the time of service for the deductible, coinsurance, or any other balances not paid for by your insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible for your bill at the time of service.

~FINANCIAL RESPONSIBILITY~

By signing this statement, you agree to be financially responsible for all charges.

Patient/Guardian Signature ________________________________ Date ___/___/_____

~AUTHORIZATION TO RELEASE MEDICAL INFORMATION~

I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is considered to be as valid as the original.

~NOTICE OF PRIVACY PRACTICES~

I have read and agree to the terms of the Notice of Privacy Practices (NPP) form.

Patient/Guardian Signature _________________________________ Date ___/___/____

If you would like a copy of the NPP form, please ask the staff at the front desk.