

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 or percentages based on your contract with them not with our office. It is your responsibility to pay in advance 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 in advance for your bill.

FINANCIAL RESPONSIBILITY

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

AUTHORIZATION TO RELEASE INFORMATION

I authorize any holder of medical information about me to release to the Health Care Financing Administration 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.

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I received the chance to review a copy of the Karwoski Family Vision Notice of Privacy Practices.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____