Signature on File

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 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 for your bill. By signing this you authorize payment of these benefits directly to Family Eye Care Center, Inc. on your behalf for any services and materials furnished.

Financial Responsibility

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

Authorization to Release Medical 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.

Patient/Guardian Signature _____ Date _____

Witness _____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practices

In the course of providing service to you, we create, receive and store health information that indentifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail.

By signing this statement I acknowledge that I have received the *Notice of Privacy Practices* from Family Eye Care Center, Inc.

Patient Signature _____ Date _____

If signing as a representative, describe relationship to the patient: _____