

**VISION CITY
OF LAKE
WORTH**
ONE-HOUR SUPERSTORE

Signature on File Form

•RESPONSIBILITY STATEMENT•

Your insurance is a method for you to reimburse the contracted fees that you have not 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. If we are not providers or if we are not in network with your insurance carrier, then we will provide you with itemized receipts to assist you in receiving reimbursement, but you are responsible in advance for your charges.

•FINANCIAL RESPONSIBILITY•

By signing this statement you agree to be financially responsible for all charges insurance does not cover.

•AUTHORIZATION TO RELEASE MEDICAL INFORMATION•

I authorize any holder that has 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 Signature _____ Date _____

Print Patient Name _____

Guardian Signature _____ Date _____

Print Guardian Name _____

Witness _____ Date _____