Patient Financial Responsibility Statement

To our patients with Medical Insurance and Vision Benefits:
It is our pleasure to help you file your insurance claim or take assignment on your vision benefit as designated by the vision plan of which you have indicated you are a member. We provide this service at no additional cost to you and will do all that we can to help you receive the maximum benefits allowable under your plan.

In the event the Plan Sponsor determines that you are not eligible at the time of service or makes a determination that you are eligible for a reduced level of coverage, by signing this agreement, you do hereby agree to be financially responsible for any and all of the charges incurred by you and paid by the Plan Sponsor.

I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for services, therefore. I agree to be responsible for payment of the balance of all services rendered on my behalf or that of my dependents. I have the right to revoke this Authorization at any time by providing the practice with a signed written request. Until such a request is received the Authorization will be in effect for six years from the date of the most recent signed Authorization.