

## **Patient Responsibility Disclosure Statement**

**Payment is due at the time services are rendered. My insurance claim will be filed on my behalf by the staff of Austin Eyecare. I authorize any holder of my medical information to provide that information to any agency necessary to determine benefits payable, compliance or utilization. I authorize and direct my insurance carrier(s) to issue payment for services rendered to Austin Eyecare. Benefits are determined by the contract between you, as the covered member, and your insurance company. I understand that payment for services are ultimately my responsibility and I agree to pay all incurred charges in full immediately upon receipt of a statement from the practice of Austin Eyecare.**

**I have read and understand the financial policy of the practice, and I agree to be bound by the terms. I also understand and agree that the practice may amend such terms from time to time.**