

## Financial Responsibility Statement

I accept all financial responsibility for all charges incurred on this account and agree to pay for all services rendered. I understand that my co-pay will be due at time of service and that I must pay half down before glasses will be ordered and the other half is due at time of pick up. ***Payment in full for contacts is required before they will be ordered.***

I understand that charges billed to my insurance company are still my responsibility if insurance denies payment for ineligibility or services are not covered. I authorize this office to furnish my insurance company all chart information they may request in order to expedite payment of this claim on my behalf. I assign and request payment be made directly to my physician(s). I authorize this signature on all insurance submissions.

I understand if I do not pay my balance within thirty days I will be charged a two dollar late fee for any remaining balance along with 2% interest. I also understand that if I write a check and it is returned I will be required to pay my balance in full by the end of the month; and that this balance will have to be paid with cash or credit. I also understand that I will be charged a twenty-five dollar returned check fee. Should my account have to be turned over to collections, I agree to be responsible for any extra fees that this office might incur due to such a situation.

Your signature is required before an exam can take place and before an order is placed.

Thank you.

Signature of patient or responsible party:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Secondary Insurance Company

Insurance Company Name: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

## Policy Holders Name

First: \_\_\_\_\_ Last: \_\_\_\_\_

Policy Holders Date of Birth: \_\_\_\_\_