Patient Financial Responsibility Statement

Patient Name: ____

Patient Date of Birth: ____/____/_____

Vision Plan Name: ____________________________________

Date of Service: ____/____/______

Member Name____

Member Number (I.D. #) ____________________________________

Relationship to Patient: ____

To our patients with vision benefits:

It is our pleasure to help you file your insurance claim forms or take assignment of your benefits 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 were not eligible at the time of service or makes a determination that you were 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 not paid by the Plan Sponsor.

Patient Signature: ______________________________Date:____/____/______
(Person responsible for payment if patient is a minor)

Patient's Billing Address:

____
Street Address

____
City, State, Zip

____
Daytime phone number

____
Evening phone number