DOWNTOWN'S VISION CARE

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information to:

_____

_____

_____

☐ Information is not to be released to anyone

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call: ☐ Home ☐ Work ☐ Cell

If unable to reach me:

☐ You may leave a detailed message

☐ Leave a message asking me to return your call

Financial Responsibility

We are glad to see you today. For those with medical insurance plans, we will file your insurance claims or take assignment on your medical/vision benefits as designated by the: _____ plan(s) of which you state you are a member. As a courtesy, we make every attempt to correctly verify your insurance benefits as they relate to services and materials we may provide to you. On occasion, we are provided with incorrect or out of date information. In all cases we will do all we can to help you receive maximum benefits. However, in the event that the plan sponsor determines that you are not eligible for coverage at the time of service, or makes a determination that you are eligible for a reduced level of coverage, by signing this statement you hereby agree to be financially responsible for any and all charges incurred by you and not paid by the plan sponsor. We can not retroactively file claims to insurance companies you do not inform us about at time of service.
For those with no insurance coverage, by signing this statement, you hereby agree to be financially responsible for any and all charges incurred by you.

I agree to be financially responsible for charges incurred by me or by the patient I represent as guardian.

Acknowledgement of Receipt of Notice of Privacy Practices

I, the patient, have received a copy of this office's Notice of Privacy Practices.

Print Name _____

Sign Name_____Date_____