ODOM'S EYE CARE, PLLC

SIGNATURE ON FILE

RESPONSIBILITY STATEMENT

Your insurance is a method for you to receive reimbursement for fees you have paid to the optometrist for services rendered. Having insurance is not a substitute for payment. Companies may have fixed allowances are percentages based on your contract with them and not with our office. It is your responsibility to pay in advance for the deductible, co-insurance, or any other balance not paid by your insurance company. We will assist you in receiving reimbursement as much as possible, but you are responsible in advance for any balance your insurance does not cover.

FINANCIAL RESPONSIBLITIY

By signing this statement you agree to be financially responsible for all charges.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoke it in writing. A photocopy of this assignment is considered to be as valid as the original.

Patient Signature ____________________________ Date __________________

Witness ____________________________ Date __________________