Thompson and Lett Eye Care

Statement of Financial Responsibility

Patient Name_____

Insurance Authorization for Assignment of Benefits, Insured Responsibility, and Release of Information

I hereby authorize and direct payment of my vision and/or medical benefits to Thompson and Lett Eye Care for any services furnished to me by the providers. I authorize the provider to release any information, including diagnosis and the records of any treatment or examination, rendered to my child or me during the period of such medical services to third party payers and/or health practitioners if applicable. In the event that my health plan determines a service to be "not covered", I will be responsible for the complete charge. I agree to be responsible for payment of all unpaid services rendered on my behalf or my dependants, including any fees for collection services needed. There will be a $20 fee on all returned checks.

I understand that an insurance contract is made between the patient and insurance company, not the provider. I also understand that I am financially responsible for my health insurance deductibles, coinsurance, and non-covered services and payment is due at time services are rendered.

_____ _____

Date Signature of Patient (or Responsible Party)

Uninsured Responsibility

I understand that full payment is due at time services are rendered. I agree to be responsible for payment of all unpaid services rendered on my behalf or my dependants, including any fees for collection services needed. There will be a $20 fee on all returned checks.

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Date Signature of Patient (or Responsible Party)

Medicare Lifetime Signature on File/ Medigap Authorization for Assignment of Benefits and Release of Information

I request that payment of authorized Medicare and Medigap (if applicable) benefits be made on my behalf to Thompson and Lett Eye Care for any services furnished to me by the providers. I authorize any holder of medical information about me to be released to the Centers for Medicare and Medicaid Services and the Medigap insurer (if applicable) and its agents any information needed to determine these benefits or the benefits payable for related services. There will be a $20 fee on all returned checks.

_____ _____

Date Signature of Patient (or Responsible Party)