Signature on File Form

• 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. Many companies have fixed allowances or percentages based on your contract with them not with our office. It is your responsibility to pay in advance for the deductible, coinsurance, or any other balances not paid for by your insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible in advance for your bill.

• FINANCIAL RESPONSIBILITY •

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 release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is considered to be as valid as the original.

• AGREEMENT TO PAY •

I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary.

• EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE •

You agree, in order for us to service your account or to collect monies you may owe, Dr. Brian R. Pettie Eyecare, PC and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I have read this disclosure and agree that Dr. Brian R. Pettie Eyecare, PC, its employees and/or agents may contact me as described above.

Patient Printed Name: _____ Date: _____

Patient or Responsible Party Signature: _____

Social security # _____

(needed if we are filing insurance on your behalf)