Patient Responsibility Form

1. Individual Financial Responsibility

- I understand that I am financially responsible for my vision/health insurance deductible, coinsurance, or non-covered service.
- Co- payments are due at time of service.
- If my vision/health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.

2. Insurance Authorization for Assignment of Benefits

I hereby authorize and direct payment of my vision/medical benefits to **(Dr. Jerry A. Richt)** on my behalf for any services furnished to me by my providers.

3. Authorization to Release Records

I hereby authorize **(Dr. Jerry A. Richt)** to release to my insurer, governmental agencies, or any other entity financially responsible for my vision/medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as, information required for precertification, authorization, or referral to another medical provider.

4. Medicare Request for Payment

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished to me by or in **(Dr. Jerry A. Richt)**. I

authorize any holder of medical or other information about me to be released to Medicare and its agents any information needed to determine these benefits or benefits for related service.

Signature of Patient, Authorized Representative, Or Responsible Party	**Date**
Print Name of Patient, Authorized Representative, Or Responsible Party	**Relationship to Patient**