



Responsible Party

All charges are due at the time of service unless we participate with your insurance company, then we will file and expect payment within 45 days. You are responsible for any unmet deductible, copayment or noncovered services including refractions.

Are you personally responsible for the payment of your fees? Please circle one.

Yes No

If yes, will you be paying? Please circle one.

Cash Check Visa Mastercard Discover

If no who will be responsible?

Name: _____ Date of Birth: _____

Address: _____

Your Relationship: _____ Phone: _____

Authorizations

Authorization for Treatment

I hereby authorize and request medical treatment by the Santamaria Eye Center staff. I further authorize the performance of whatever procedure the judgement of the above named staff may deem necessary during any treatment. I also authorize the administration of any anesthetics and analgesics which above staff may deem advisable. (Note: Eye drops and eye medications are considered anesthetics and analgesics.)

Financial Agreement

I acknowledge that payment is due at the time of treatment, unless other arrangements have been made. I accept full responsibility for all charges not covered by my insurance company. The above information is accurate and complete to the best of my knowledge.

Assignment of Benefits

All insurance forms processed by this office require assignment of benefits to this practice unless payment in full is made. Your cooperation in complying with the terms of this assignment is appreciated. I, the undersigned, hereby authorize payment of medical and surgical benefits directly to SANTA MARIA EYE CENTER.

Authorization to Release Information

I hereby authorize my doctor/doctors to furnish the insurance company all information necessary to secure payment of benefits.

Patient/Parent or Guardian Signature

Date