# VitalEyes, LLC

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## Notice of Financial Responsibility
## Signature on File

Patient's Name__________________________________________ Patient's DOB ____/____/____

Legal Guardian/Parent's Name_____________________________________ DOB____/____/____

I understand and agree to be fully responsible for the payment of all charges incurred as a result of this or any subsequent office visit(s). I understand and agree to accept responsibility for payment of all claims should my insurance carrier deny all or part of a claim. I understand and agree that all insurance deductibles and any incurred expenses not covered by my health insurance carrier must be paid for at the time of service.

I hereby authorize payment directly to VitalEyes, LLC for any products or services rendered to me by either Dr. Eric Patten or Dr Julie Patten and authorize VitalEyes, LLC to assist me in obtaining payment from my health insurance companies.

I authorize the release of all medical information to the insured patient's health insurance carrier that is acquired in the course of my examination or treatment and may have a bearing on the benefits payable under this or any other health insurance or vision plan that provides benefits or services.

I authorize this "Signature on File" to be used on all insurance claim submissions, including, but not limited to Medicare, Medical Mutual, Anthem Blue Cross Blue Shield, and Aetna.

_______________________________________ _________/_________/_________

Insured or Authorized Person's Signature Today's Date