



SIGNATURE ON FILE / FINANCIAL RESPONSIBILITY

- ♦ I authorize Werner Optometry to use my name on any and all claims or documents that relate to health insurance benefits due to me and my dependents.
- ♦ I authorize release of any information related to any claims to all my Insurance Companies or other relevant parties.
- ♦ I authorize payment of health benefits otherwise payable to me, directly to Werner Optometry
- ♦ I understand I am financially responsible, whether my insurance company pays or not, for all charges incurred by me. I further agree that in the event of nonpayment, I will bear the cost of collection and / or court costs and reasonable legal fees should such action be required.
- ♦ **Medicare Only:** Werner Optometry agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services.
- ♦ I understand that 48 hours notice is required if I am unable to keep my appointment. Otherwise, a \$35.00 Cancellation Fee will be charged.
- ♦ I understand that payment is due at the time services are rendered.
- ♦ I permit a copy of this authorization to be used in place of the original.

Print Name (Patient, Parent or Guardian)

Date

Signature

Relationship

ACKNOWLEDGEMENT OF RECEIPT OF H.I.P.A.A. PRIVACY POLICY

I acknowledge that I received a copy of Werner Optometry Notice of Privacy Practices.

Patient Name _____
Print Name of Patient

Signature _____ Date _____
Signature (Patient, Parent or Guardian)

Effective Date of Notice: August 18, 2020