

## Financial Responsibility Statement

To our patients with Insurance Benefits:

**Leverett Eyecare, P.C.**  
**Marcia K. Leverett, O.D.**  
**812 S. Lynnhaven Road, Suite100**  
**Virginia Beach, VA 23452**  
**757.486.2015**

We are committed to providing you with the best possible care. If you have vision or medical insurance, we are happy to help you receive your maximum allowable benefits. We must emphasize that, as vision care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. By signing this statement, you do hereby agree to be financially responsible for any and all of the charges incurred by you and are not paid for by your insurance plan.

**Please complete the following information and sign on the appropriate line. Thank you.**

**PATIENT'S NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

**GUARDIAN'S NAME (if applicable):** \_\_\_\_\_

### **SIGNATURE ON FILE:**

- ❖ I authorize the use of this form on all my insurance submissions
- ❖ I authorize my doctor to act as my agent in helping me obtain payment from my insurance carrier(s)
- ❖ I authorize payment direct to my doctor
- ❖ I permit a copy of this authorization to be used in place of the original

**PATIENT OR GUARDIAN SIGNATURE:** \_\_\_\_\_

**TODAY'S DATE:** \_\_\_\_\_

**CONFIDENTIAL:** The PHI (personal health information) contained in this form is **highly confidential**. It is intended for the exclusive use of authorized personnel. It is to be used only to aid in providing specific healthcare service to this patient. Any other use is a violation of Federal Law (HIPAA) and will be reported as such.