OPTOMETRY CORNER

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Notice of Financial Responsibility
Notice of Privacy Practices
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 Optometry Corner for any products or services rendered to me by either Dr. Hawkin Lui or Dr. Dan Gilbert and authorize Optometry Corner 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.

Acknowledgement of Receipt of Privacy Notices:
I acknowledge that I have read and/or received the Notice of Privacy Practices from Optometry Corner, which can be obtained from our office or online at www.OptometryCorner.com

I authorize this "Signature on File" to be used in place of the original and that this copy may be used on all insurance claim submissions, including, but not limited to Medicare, United Healthcare, Cigna, and Humana.

_____ ____/____/____
Insured or Authorized Person's Signature Today's Date