

have not received payment we will send you a statement so you will know that your insurance has not paid. If after 60 days we have not received payment the balance will then become your responsibility.

Thank you for your understanding and cooperation. Should you have any questions or need further clarification, please check with our office personnel.

I have read and understand the written policy of this office. I agree to make arrangements for payment of the balance in full accordance with this policy. I authorize the release of any medical information necessary to process claims for Dr. Fitzgerald & Associates.

Will you be using any insurance today?    Yes             No

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Primary Card Holders Name

\_\_\_\_\_  
Social Security Number of Card Holder

\_\_\_\_\_  
Date of Birth of Policy Holder

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Billing Address of Card Holder

**Consent for Release of Information  
Responsibility for Payment for HIPPA**

I consent to the use and disclosure by the Office any information, e.g. health information concerning my vision examinations and products, to any party and/or agent, including but not limited to my employer, health plan or plan sponsor, as needed for my treatment, the payment of my vision benefit claims, and related customer communications regarding health care services provided by the office (e.g. mailings of exam reminder/recall cards or explanations of services/products provided by the office).

If I desire to seek third party reimbursement for the services received, I authorize the Office to submit a vision benefit claim for payment to any third party as identified. I understand that I am responsible for all charges incurred, including any portion not paid by any third party.

\_\_\_\_\_  
Signature (Patient or Legal Representative)

\_\_\_\_\_  
Date