EYE-SITE OF BOYNTON BEACH
6641 W BOYNTON BEACH BLVD
BOYNTON BEACH, FL 33437
PH: 561-738-0111
FX: 561-735-9359

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

I hereby authorize the vision care provider to apply for benefits on my behalf for covered services rendered by them. I assign my benefits and request that all payments from insurance are made directly to the vision care provider. I agree to assume financial responsibility for full payment pending any balance that is not covered by my insurance. I certify that the information I have reported with regard to my coverage is correct. I authorize the vision care provider to release to my insurance company any information related to this claim.

Patient Name: _____

Patient Signature: _____ Date: ____/____/_____

NOTICE OF PRIVACY PRACTICES

Our full Notice of Privacy Practices is available for your review in our office. You may request a paper or electronic copy at any time, and we will provide it promptly.

PATIENT ACKNOWLEDGEMENT:

I have been informed that Eye-Site of Boynton Beach Notice of Privacy Practices is available upon request.

Patient Name: _____

Patient Signature: _____ Date: ____/____/_____