FINANCIAL RESPONSIBILITY/HIPAA FORM

Patient's Name: _____

Please mark those that apply:

☐ **Insurance coverage:** At this time, I believe that I am still covered by insurance. I understand that I will be responsible for any amount due if, for some reason, my exam and/or material charges are denied, including any deductibles not met for the year. Insurance benefits, as quoted by your individual insurance company, and in turn quoted to you by our office, are an ESTIMATE of payment only. I understand that my insurance carrier may pay less than the actual bill for services. I am also aware that I am responsible for any non-covered service(s) or material(s) that I request.

☐ **No Insurance:** I do not have active vision/medical coverage and are responsible for services and/or hardware payment at the time of service.

☐ I have been offered the **HIPAA** privacy policies of Downtown Vision Centre and Camas Vision Centre that went into effect April 14, 2003

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATE

RELATIONSHIP IF SIGNED BY ANYONE OTHER THAN PATIENT