## Payment for Services, Financial Responsibility, and Authorization Statement

Payment for all services and products is the responsibility of the patient.

I agree to pay all copays, deductibles, co-insurances, and non-covered services as determined by my insurance company.

I agree to pay an additional collection fee for all accounts not paid in the time stated on the final monthly statement.

I authorize the release of medical information concerning my illness and treatment to my insurance company.

I authorize the release of my personal medical information to any doctor whom I may be referred to.

I understand verification of eligibility is not a guarantee of payment as stated by my insurance company.

I authorize payment of my insurance benefits to **Blinc Eye Care.**

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Printed Name of Patient or Legal Guardian

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Signature of Patient or Legal Guardian Today's Date

Blinc Eye Care
791 Fish Creek Thoroughfare, Suite 50
Montgomery, Texas 77316