Werner Optometry, A.P.C.
2650 Jamacha Rd. Suite 155
El Cajon, CA 92019
(619) 670-6296

SIGNATURE ON FILE / FINANCIAL RESPONSIBILTY

- I authorize Werner Optometry, A.P.C. to use my name on any and all claims or documents that relate to health insurance benefits due to me and my dependents.
- I authorize release of any information related to any claims to all my Insurance Companies or other relevant parties.
- I authorize payment of health benefits otherwise payable to me, directly to Werner Optometry, A.P.C.
- I understand I am financially responsible, whether my insurance company pays or not, for all charges incurred by me. I further agree that in the event of nonpayment, I will bear the cost of collection and / or court costs and reasonable legal fees should such action be required.
- I understand that 48 hours notice is required if I am unable to keep my appointment. Otherwise, a $35.00 Cancellation Fee will be charged.
- I understand that payment is due at the time services are rendered.
- I permit a copy of this authorization to be used in place of the original.

_____ _____
Print Name (Patient, Parent or Guardian) **Date**

_____ _____
Signature **Relationship**

AKNOWLEDGEMENT OF RECEIPT OF H.I.P.A.A. PRIVACY POLICY

I acknowledge that I received a copy of Werner Optometry, A.P.C. Notice of Privacy Practices.

Patient Name _____
Print Name of Patient

Signature _____ Date _____
Signature (Patient, Parent or Guardian)

Effective Date of Notice: January 14, 2003