Dr. Peter A. Thomas
& ASSOCIATES

STATEMENT OF FINANCIAL RESPONSIBILITY / BENEFITS ASSIGNMENT AND RELEASE

I understand that I am financially responsible for all charges, whether or not paid by insurance.

In the event that I do have vision/medical insurance accepted at this practice, I certify that I, and/or my dependent(s), have coverage with _____ and assign directly to Dr. Peter A. Thomas all insurance benefits (if any) otherwise payable to me for services rendered.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company / companies and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

In the event that I do not have insurance, I understand that I will be responsible for paying for all services and that payment must be rendered at time of service.

_____ _____

Signature of patient, guardian or personal representative | Date

_____ _____

Please print name of patient, guardian or personal representative | Relationship to patient