Northsight Vision Care
14100 N. Northsight Blvd
Scottsdale, AZ 85260
480-443-1150 FAX: 480-443-7393

SIGNATURE ON FILE FORM

Responsibility Statement:
Your insurance is a method for you to receive reimbursement for fees for services rendered. Having insurances is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them, not based on an agreement with our office. It is your responsibility to pay in advance for the deductible, coinsurance, or any other balances not paid by your insurance. We will assist you in receiving reimbursement as much as possible through your insurance contract.

Financial Responsibility: By signing this statement you agree to be financially responsible for all charges.

Authorization to release medical information: By signing this statement below you authorize us to release to the Health Care Financing Administration and its agents any information needed to determine benefits or benefits payable for related services. The assignment will remain in effect until revoked in writing. A photocopy/ scan of this assignment is considered to be as valid as the original.

Your Name: _____

Signature:_____
Patient or responsible party

Date:_____