

MARTINEZ EYE ASSOCIATES
3412 Wrightsboro Road
Suite 905
Augusta, GA 30909
(706) 736-3937

Financial Responsibility

Patient:

Date: 07/07/2010

To our patients with Medical and/or Vision benefits:

We will be happy to file your insurance claim forms or take assignment on your medical/vision benefits as designated by the:

(Medical) and/or

(Vision)

Plan(s) of which you state you are a member. We will do all we can to help you receive maximum benefits. However, in the event that the plan sponsor determines that you are not eligible for coverage at the time of service, or makes a determination that you are eligible for a reduced level of coverage, by signing this statement you hereby agree to be financially responsible for any and all charges incurred by you and not paid by the plan sponsor.

Signature of patient or person acting on patient's behalf

Date