PATIENT STATEMENT FOR **NON-HMO** PATIENTS

I certify that **I am NOT** a member of any Health Maintenance Organization (HMO). If I am enrolled in an HMO or fail to get proper authorization prior to treatment, I agree to take full responsibility for the entire amount of any charges that I may incur.

Signature of Patient Date

Witness

PATIENT STATEMENTS FOR **HMO** PATIENTS

I certify that **I AM** a member of the Health Maintenance Organization (HMO) listed below. I am aware that is my responsibility to make sure that I have proper authorization in order for services to be covered. I will take full responsibility for any charges that are not covered due to lack of proper authorization or denial by my HMO for any reason.

Name of HMO of which I am currently a member: _____

Signature of Patient Date

Witness

I certify that **I AM** enrolled in a Health Maintenance Organization (HMO) which Coastal Eye Center may or may not have a participating provider agreement. I prefer to be seen WITHOUT waiting for the necessary authorization. I take full responsibility for the entire amount of any charges I incur.

Signature of Patient Date

Witness