

## SEASIDE EYECARE OPTOMETRY

Jean M. Lim O.D.  
638 Camino de los Mares, A120  
San Clemente, CA 92673  
949-493-2269

### PATIENT FINANCIAL RESPONSIBILITY

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I acknowledge full financial responsibility for services and materials rendered by Dr. Lim, and her associates. I understand that I am financially responsible for all charges whether or not paid for by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits from my insurance company. I authorize the use of this signature on all my insurance claims submissions. I assign directly to Dr. Lim (Seaside Eyecare Optometry) all insurance benefits, if any, otherwise payable to me for services rendered.

**I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance, including deductible, co-pays and co-insurance.** I understand payment of co-pays is expected at the time of service, as well as any prior balance I may owe. Unpaid balances are due within 90 days from the receipt of the statement.

Patient Signature of Understanding: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

