COLORADO
OPHTHALMOLOGY
ASSOCIATES, P. C.

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Stephanie A. Melzer, O.D.

Patient Responsibilities

I, the undersigned, in consideration for services being rendered to the patient by **Colorado Ophthalmology Associates, P.C.**, understand and agree to the following:

1) I understand that payment for charges, including co-payments, are due on the date of service.

2) I hereby authorize **Colorado Ophthalmology Associates, P.C.** to file with my insurance carrier and I assign payment of medical benefits to **Colorado Ophthalmology Associates, P.C.**

3) I will keep my account current as to charges for which I am responsible, in the event that I fail to pay charges, **Colorado Ophthalmology Associates, P.C.** is entitled to take whatever action is necessary to collect such charges and I will be responsible for reasonable attorney fees and costs incurred as a result of such collection.

4) I authorize release of any and all medical records and information necessary for continuation of care and for processing any claims associated with services I receive in this office.

5) I understand that my insurance benefits and referral requirements are my responsibility. **Colorado Ophthalmology Associates, P.C.** will assist me in any areas possible, but ultimately, I am responsible to understand my benefits and obtain any referrals necessary.

6) I will be sure to inform **Colorado Ophthalmology Associates, P.C.** anytime my personal information or insurance coverage has changed.

My signature below indicates I agree to the terms set above.

_____ _____

Patient or Responsible Party Signature Date