



Steve Randle, O.D.
Optometry

*ACCEPTANCE OF FINANCIAL RESPONSIBILITY FOR
TREATMENT*

I agree that if my eligibility of coverage by my HMO or PPO Healthcare Plan can not be confirmed at the time of my appointment or if I am not eligible for coverage, or coverage has expired at the time the services have been rendered, that I will hereby take full responsibility for payment of any and all services rendered to me.

Patient signature

Date

Witness

Date