PATIENT RESPONSIBILITY STATEMENT

Date: ______________________________

I, ______________________________ (patient name), understand that I am seeing

Dr. ______________________________ (provider name) without:

- ❏ Verification of eligibility for services by VSP®
- ❏ A required referral from my Primary Care Physician
- ❏ Other: ______________________________

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I understand that if my eligibility cannot be verified, or if I do not obtain the proper referral form when required, I will be financially responsible for payment of all charges incurred for services received from this doctor's office.

Signature of patient: ______________________________

Parent/guardian signature (if minor): ______________________________

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