DR. ARTHUR ELEFTHERIO, O.D.
7645 Leesburg Pike
Falls Church, VA 22043
(703)790-0808

PAYMENT AGREEMENT

I, _____ understand
that I am responsible for all charges applied to my account for services
rendered to me and my family.

In the event this office submits an INSURANCE claim on my behalf,
I am responsible for and agree to pay any portion of my charges that
the INSURANCE does not cover.

Signature_____ Date _____

SIGNATURE ON FILE

- I authorize use of this form on **all** my insurance submissions.
- I authorize release of information to all my **Insurance Companies.**
- I understand that **I am responsible** for my bill.
- I authorize my doctor to act as **my** agent in helping me obtain payment from my Insurance companies.
- I authorize **payment directly to Dr. Eleftherio.**
- I permit a copy of this authorization to be used in place of the original.

Name (Please Print)_____

Signature_____

Date _____