VISION ASSOCIATES OF HACKETTSTOWN

Vision Associates of Hackettstown

Financial Guarantor Information

Today's Date: _____

Last Name: _____ First Name: _____ MI: _____

Street Address: _____

City/Town: _____ State: _____ Zip: _____

Daytime Phone: _____ Alternate Phone: _____

Gender: Male: _____ Female: _____ DOB: _____ / ____ / _____

SS Number: _____ Employer: _____

FINANCIAL AGREEMENT

I will be responsible for any financial obligation incurred in connection with my vision exam and treatments. I understand that payment must be made at the time services are rendered. I further understand I am also responsible for any charges incurred which are not covered by my insurance. I will be subject to finance charges for unpaid balances after 90 days.

Our office will apply a $25 collections fee to any account that is left unpaid after 90 days. Those accounts will be sent to collections for the unpaid amount.

We ask that all patients know their vision and medical insurance prior to your scheduled appointment. If incorrect information is given, you may end up responsible for full payment of services and obtaining reimbursement from your correct vision carrier yourself. **Our office does not backdate claims for payment**.

Signature of Patient or Guardian Date