Precise Family Eyecare, P.C. will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your vision or medical benefits is between you, your employer, and your insurance company. The obligation you have to our practice is to pay for your services, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

* Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.

* We ask you to sign this form and or any other necessary documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.

* We ask you to pay the estimated co-payment or deductible, which is the amount not covered by your insurance company, at the time we provide service to you. In addition, you are acknowledging that services rendered:

_____

is/are not included in your insurance benefits, is your responsibility, and need to be paid by you today.

* Insurance payments ordinarily are received within thirty to 60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company at that time.

* We perform routine insurance billing procedures upon verification of coverage. Our office does not guarantee that your insurance company will pay for services you receive from our practice. Therefore, if your claim is denied, you will be responsible for paying the full amount at that time.

* We will cooperate fully with the regulations and requests of your insurance company. Our office will not enter into a dispute with your insurance company over any claim, although we will provide the necessary documentation your insurance company requests to sort out any confusion or questions that may arise. It is ultimately your responsibility to resolve any type of dispute over payment made or not made by your insurance company.

I HAVE READ AND UNDERSTAND THE ABOVE CONDITIONS. I HEREBY AUTHORIZE MY INSURANCE COMPANY TO PAY MY VISION BENEFITS DIRECTLY TO THE DOCTOR.

_____

Print Name Date

Signature of Patient /Responsible Party:_____