PATIENT VISITATION AND FINANCIAL RESPONSIBILITY STATEMENT

Billing / Insurance Information:
You must provide your insurance information and a copy of your ID card(s) at each visit. **Payment of your required co-pay and any non-covered services are required at time of service.** We may also request payment for deductibles and co-insurance if provided by your insurance carrier at time of service.

We participate or contract with most major insurance carriers, including Medicare and Medicaid, but it is your responsibility to confirm benefits and coverage prior to services provided. We will submit claims to your insurance carrier, but you remain responsible for any charges incurred regardless of your insurance coverage. All unpaid balances will be billed to you as self pay and are due and payable within 30 days of the statement date. Past due balances may be subject to outsourcing to a third party agency for collection.

Your insurance carrier can tell you whether we are contracted with them. For any insurance plans that we do not participate or contract with, you are responsible for any unpaid balance and if unable to pay in full you must make payment arrangements with our billing staff.

It is your responsibility to:
- Know your insurance benefits and coverage.
- Know whether a referral is required.
- Know whether pre-certification for a procedure or surgery is required.
- Notify us of changes to your insurance plan or coverage.

Managed Care Medicaid and Managed Care Insurance recipients MUST bring a copy of the referral card from your primary care physician or your appointment may be rescheduled. Your insurance card will state 'Referral Required' or contact your insurance carrier for verification. If you choose to be seen without a required referral, you accept responsibility for payment prior to services provided. (This does not apply to Medicare patients).

Cosmetic and Elective Surgery:
Fees for cosmetic or elective services, including premium lens implants, not covered by insurance must be paid one week in advance of scheduled surgery or surgery may be cancelled. An **estimate** of fees will be provided prior to services provided. Final fees in excess of the estimated fees will be billed to you; overpayments will be refunded.

Credit Cards:
We accept the following credit cards: Visa, Mastercard, American Express, Discover

Pre-authorization:
Our billing staff will assist in obtaining any required pre-authorizations and benefits detailing your financial obligations prior to your procedure or surgery.

Refractions:
A refraction is the exam that is performed during your office visit to determine your best possible vision ("which is better, one or two?"), and for diagnosis of eye disease. **Routine refractions for glasses prescriptions are usually not covered by medical insurance plans including Medicare. If you request a copy of your glasses prescription, a refraction fee of $40 must be paid at the time of service.** If you are not satisfied with your new glasses, we will recheck the refraction at no charge to you, provided you contact us within 60 days of your initial exam. All glasses prescriptions expire after 12 months. We do not provide copies of expired prescriptions.

Self-Pay:
Payment is expected at the time of service. Payments may be made by cash, check, money order, or credit card. You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, co- insurance amounts or any other patient responsibility indicated by your insurance carrier which are not otherwise covered by supplemental insurance.

Surgery:
We will provide an estimate of expected physician fees at your request, including anesthesia and facility fees if services are incurred. You may also receive a bill from other providers of care such as pathology, lab, or other facility for some services.

Missed Appointments
Once your appointment has been confirmed it will be reserved for you to meet your eye care needs. Please be courteous to our staff and fellow patients by keeping your confirmed appointment. If you are unable to keep your confirmed scheduled appointment, please inform us as soon as possible. We do require a 24-hour notice of cancellation of your confirmed appointment. A minimum fee of $50.00 may be charged to your account for broken appointments based on the amount of time and service reserved for you.

Acknowledgement

By signing below, each of the undersigned acknowledges that: (i) I have been provided a copy of the PATIENT VISIT AND FINANCIAL RESPONSIBILITY STATEMENT; (ii) I have read, understand, and agree to their provisions and agree to the specified terms; (iii) I agree to pay all charges due (or to become due) for the below Patient's care and treatment, including co-payments and deductibles, as required or provided pursuant to my insurance plan and/or the insurance plan of another, as applicable; (iv) benefits, if any, paid by a third-party will be credited on the Patient account.

I further agree that a photocopy of this Patient Visit and Financial Responsibility Statement shall be as valid as the original.

ONCE I HAVE SIGNED THIS AGREEMENT, WHETHER BY ORIGINAL, FACSIMILE OR ELECTRONIC (".PDF") SIGNATURE, I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.

Signature: _____

Patient name: _____

Responsible Party Name: _____

Role (circle one): Patient/Responsibility Party/Guardian

Date: _____