

**FINANCIAL POLICY**

We are committed to providing you with the highest level of service and quality care. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, however, any and all financial liability rests with the patient.

Our office participates with most major insurance plans. We provide MEDICAL AND SURGICAL ophthalmologic care to our patients, as opposed to routine eye exams. We do not participate with any vision plans. If you have a managed care plan that requires a referral to see a specialist, you are responsible for obtaining a referral in order for your visit in our office to be covered under your medical insurance. If you do not have a valid referral and still wish to be seen, you will be asked to pay for the visit prior to your examination.

It is the patient's/parent's/guardian's/responsibility to:

Be familiar with the benefits of your plan, including co-pays, coinsurance and deductibles.

Bring all of your insurance cards to each visit.

Bring all of your current information including address, phone numbers and employer.

In accordance with your insurance contract, you must be prepared to pay your co-pay at each visit.

We accept cash, checks and most major credit cards for services.

We appreciate prompt payment in full for any outstanding balance. If your account is turned over to our collection agency, you agree to pay any fees imposed by the collection agency in order to collect the overdue amount. Any check payments that do not clear the bank will be subject to a \$25.00 returned check fee.

For all services rendered to minor/dependent patients, we will look to the adult accompanying the patient and/or the parent or guardian with whom the child resides for payment. In cases of separation or divorce, when presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply their name, address, phone number and date of birth. We request you inform the subscriber their insurance has been used.

I have read and understand the above financial policy.

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**Patient/Guardian Signature**

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**Date**