Patient Responsibility

Patient Name:_____
Date:_____

We are pleased to assist you with your vision/medical insurance. If you have vision/medical insurance, please be aware that insurance quotes are an ESTIMATE only. Coverage may be different if your deductible has not been met, annual maximum has been met, or if your plan coverage is lower than average.

INDIVIDUAL'S FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
-Co-payments are due at time of service.
-In the event that my health plan determines a service to be "non payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
-If my insurance determines that I have not met my deductible, I understand that I will be fully responsible for payment in a timely manner, no more than 30 days after I have been notified by insurance and/or provider.
-If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

NON-PAYMENT ACCOUNT:

Should collection proceedings or other legal action become necessary to collect overdue amount, the patient's responsible party should understand that Parmer Eye Care has the right to disclose to an outside Collection Agency all the relevant personal and account information necessary to collect payment for services rendered. The patient, or patient's responsible party, understands that they are responsible for all cost of collection. This will be added to the outstanding balance.

I acknowledge that I assume full financial responsibility for services rendered to me, if my insurance carrier denies or does not cover my claim for these services. I understand that I am responsible to contact my insurance carrier regarding any questions about my coverage, my co-pays, my deductible and any other billing questions I may have. I understand the terms of this form and accept financial responsibility with or without the use of insurance coverage.
NOTE: when our office receives an Explanation of Benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

_____ _____
Patient/Guardian Signature Date

Please note a $35.00 fee will be charged for all returned checks.