Patient Financial Responsibility

1. FINANCIAL RESPONSIBILITY: I agree to pay Generations Family Eyecare, for any and all services rendered or expenses incurred as the responsible person on this account. I understand that bills are payable in full upon the rendering of treatment. However, we will bill any applicable insurance as a courtesy. I assign Generations Family Eyecare all benefits due me for services rendered and expenses incurred under any applicable policy of insurance. I understand that I am financially responsible to Generations Family Eyecare for all charges and services not covered by this assignment and promise to pay any remaining balance.

2. COLLECTION POLICY: An account is considered delinquent when insurance has not paid within 60 days after Generations Family Eyecare billing or if payment in full has not be received within 30 days of the final insurance payment. Delinquent accounts may be turned over to a collection agency.

ABOUT YOUR INSURANCE

There are two types of health insurance that may help pay for your eye care services and materials. You may have both and our practice accepts both: 1) Medical Insurance (such as Blue Cross/Blue Shield and Medicare) and, 2) Vision Insurance (such as VSP and EyeMed). Vision insurance only covers ROUTINE VISION EXAMS along with eyeglasses and contact lenses. Medical insurance must be used if you have any eye health problem that has ocular complications. Your doctor will determine if these conditions apply to you but some are determined by your case history. Most medical insurance plans do have routine vision screening benefits but these are very different than an actual vision examination. Vision screenings are basic screenings for eye disease. They do not cover diagnosis, management or treatment of eye diseases nor do they allow for a prescription to be written for eyeglasses or contact lenses. If you have both types of insurance plans, it may be necessary for us to bill some services to one plan and other services to the other plan. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense. We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits in an attempt to let you know what is covered. Any co-pays, deductibles or non-covered services will be your responsibility. Fees for professional services are non-refundable and materials must be paid in full before being dispensed.

Patient Name: _____

Patient or Legal Guardian Signature: _____ Date: _____