

San Gabriel Eye Center

Patient Financial Responsibility Disclosure Statement

Medical Insurance

We have contracts with many insurance companies. We will bill them as a service for you. As the *Patient* or *Responsible Party*, you are responsible for any balance if your insurance company refuses to pay for any reason.

The person signing on behalf of the *Patient* as the *Responsible Party* must:

- ✓ Inform San Gabriel Eye Care of the current address and/or phone number for the *Patient* and *Responsible Party*.
- ✓ Present all current insurance cards (Vision and Medical) prior to each visit.
- ✓ Pay any required co-pay at the time of the visit.
- ✓ Pay any additional amount owing within 30 days of receiving a statement from our office.

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.

Non-Payment on 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 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 costs of collection. This will be added to the outstanding balance.

Please Note: A \$30.00 FEE WILL BE CHARGED FOR ALL RETURNED CHECKS.

By signing below, you agree to accept full financial responsibility as a *Patient* who is receiving medical and/or vision 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 Name (Please Print)

Patient Signature / Date

Responsible Party Name (Please Print)

Responsible Party Signature / Date
