FAMILY EYE CENTER

for the life of your eyes

EMAIL:_____

How did you hear about Family Eye Center? ***(We would like to thank the person or business that referred you to our clinic,)***

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FINANCIAL LIABILITY AND ASSIGNMENT OF BENEFITS

We welcome you to our office and appreciate the opportunity to provide you with medical services. We strive to provide the highest quality eye care to our patients. We make every effort to keep down the cost of your medical care. It is our policy to ask for payment at the time of your visit.

Payment for all professional services rendered is due at the time of service. If you have a vision plan or medical insurance, it is your responsibility to ensure we have correct and current information for your insurance plan. It is also your responsibility to pay the copay at the time of service per our contract with your insurance company.

Family Eye Center offers a same day discounted fee schedule. Payment for services rendered is required at time of service.

ASSIGNMENT OF BENEFITS

I hereby assign all medical benefits, to include major medical benefits, to which I am entitled, to Family Eye Center for services rendered. I hereby authorize and direct my insurance carrier (including Medicare, private insurance and any other medical or vision plan) to issue payments directly to Family Eye Center for health care services provided to me and /or my dependent regardless of my insurance benefits, if any. I understand that I am financially responsible for copay, coinsurance and deductible at the time of service and for any services rendered that are determined to be non covered by my plan.

I certify that the insurance information I have provided to Family Eye Center is true and that it is my obligation to know my plan's requirements and ensure that they have been fulfilled. I understand that my insurances may not pay 100% of the amount of the claim for services rendered and that I am responsible for any and all amounts not payable by my insurance that are assigned to me. I agree to notify Family Eye Center of any changes in the information I have provided.

Your insurance contract is an agreement between you and your insurance carrier. We participate with most major insurance carriers. As required by most insurance carriers, you are responsible for the payment of deductibles, co payments and any non covered services at the time of your office visits. It is your responsibility to get an authorization or referral from your insurance company or primary care physician.

I acknowledge that I am fully responsible for all costs incurred during my treatment at Family Eye Center. I understand that any part of my account that is not paid in a timely manner may result in interest being charged to my account, which I agree to pay. I agree to pay any and all legal and collection costs on my account in full.

Please remember that regardless of insurance coverage, you are responsible for your bill. If the insurance information you give us at the time of your visit is not correct, you will be held responsible for payment.

_____ _____

Printed Patient Name **Patient Date of Birth**

_____ _____

Printed Insured Name **Insured Date of Birth**

_____ _____

Relationship to Patient **Insured Social Security #**

_____ _____

Patient/Insured/Guarantor Signature **Date**