Financial Agreement and Disclosure

Responsible party initial the following, as record of disclosure.

1) Estimated Fees for all services, including deductibles, co-payments, unpaid balances and non-covered services are due at the time of service, unless otherwise specified and noted by management. Once your insurance has processed the claim(s) you will receive a statement for any balance deemed your responsibility. Payment is due upon receipt of statement. If insurance pays you directly for services billed by Family Eye Care it is your obligation to forward payment to us.

2) Unpaid balances are subject to collections and associated collection agency fees. Returned check fees, up to $25, will be billed directly to you for each returned check we incur.

3) You are responsible for all portions assigned by your insurance carrier as your responsibility (deductibles, co-insurance, co-pay, non-covered services). We accept both vision and medical plans. The type of service you receive dictates which insurance we bill. Vision plans cover routine eye exams and eyeglasses/contact lenses. All other billable services are usually sent to medical plans.

4) We will not become involved in disputes between you and your insurance regarding deductibles, coinsurance, co-payments, non-covered services, etc. Contact your insurance representative and understand your coverage and benefits prior to undergoing any service/procedure.

5) A refraction fee of $25.00 will be collected following services or with a mailed statement when it is necessary to perform with medical visits.

For further details on our policies, please request a copy of our Statement of Financial Responsibility.

Responsible party sign the following, as record of disclosure.

I understand the above information and am responsible for the patient listed below.

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Printed Name of Patient

____ ____________________

Signature of Patient/Responsible Party Date