Patient Responsibility Statement

Thank you for choosing our office for your eye care needs. As your eye care provider, we are committed to providing you the best eye care services possible. Please understand that payment of your bill is considered a part of your care. The following statement explains our Financial Policy, which we ask you to read and sign.

1) Services are rendered to the patient, not the insurance company. As a courtesy, our office will file your insurance claim if proper information is received.
2) **All applicable co-pays and non-covered services payments are due at the time of service.**
3) Please be aware that some of the services provided may be non-covered services. It is the responsibility of the policy holder to know what services may not be covered. As a courtesy, our office will do our best to ascertain what those may be and advise you of such.
4) We participate in numerous plans. For some insurance plans, we accept assignment of benefits but in all cases, we require the guarantor, the person who is financially responsible, to be personally liable for all balances not covered by insurance. **While we make every effort to verify and confirm your insurances benefits, it is your responsibility to understand the terms and conditions of your insurance plan.**

Statement of Acknowledgement:

I (**print name**)_____ have read and understand the above policy. I hereby accept the above policy and further agree that I shall be responsible for any balance due that insurance does not cover.

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Patient/Legal Guardian of Minor Patient **Signature** Date