EYECARE ASSOCIATES

FINANCIAL RESPONSIBILITY

Patient's Name_____ **Date of Birth** _____
(Please print)

Cell Phone Number: _____ **Texting ok? Yes or No**

Email Address (please print legibly) _____

Mailing Address_____

It is our office policy to inform you of our payment procedures. Please review and initial the section below that is applicable. **All accounts not paid within 60 days are subject to a 1.5% interest charge.**

Contact lens services are subject to additional fees that are not included below.

_____ 1. **Patient without Insurance (Private Pay)**

Please make payment for your care at each visit. If payment cannot be made at each visit, arrangement must be made with our billing department prior to your visit.

_____ 2. **Patient with Insurance**

You are responsible for deductibles, co-pays, non-covered services (such as the **Optomap** which is $39), co-insurance, and items considered "not medically necessary" by your insurance company. Please pay co-payments and co-insurance amounts as services are rendered. The remaining balance should be taken care of within one (1) month of notice from insurance company unless other arrangements are made with our billing department. If you or your insurance carrier make payment exceeding your balance, reimbursement will be remitted. If payment cannot be made at each visit, notify the billing department to make other arrangements.

_____ 3. **Medicare**

Our office will submit your Medicare charges to Medicare and your secondary insurance. You are responsible for deductibles, copays, and any non-covered services such as the **refraction ($20)** and the **Optomap ($39)**.

I have read and I agree to the financial policy information stated above that applies to me.

_____ _____
Patient (or responsible party) signature Date

_____ _____
Person signing on behalf of patient (please print name) Relationship to patient

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