SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

Patient Name: _____

Chart Number: _____ Date of Birth: _____

I understand that it is my responsibility to check with my insurance company to verify what my policy may or may not cover.

I accept full financial responsibility for any charges incurred today if:

1. The services rendered or supplies used/purchased are not covered under my insurance plan;
2. My insurance plan requires that I pay a deductible, co-payment, or co-insurance;
3. There are charges that have resulted because I have failed to provide current and valid insurance policy information; or
4. My insurance plan requires that I obtain a referral prior to my visit and I do not have one in place.

I agree:

1. Payment be made to The Eye Care Group, PC (TECG) by my insurance carrier for services rendered or product received;
2. TECG may use and disclose medical information about me for services and procedures so they may be billed and collected from an insurance agency or any other third party;
3. To pay for my co-pay and other charges that are not covered by my insurance carrier today or make financial arrangements satisfactory to TECG for payment;
4. If I am not able to pay TECG for balances within 30 days, to pay a 1% interest charge, compounded, per month for my balance.
5. To pay a $15.00 service fee for any copayment not paid at the time of service.
6. To pay for any returned check fees incurred by TECG.
7. If I am the parent/guardian bringing in a child for treatment, that I am responsible for all fees incurred by the child.
8. To pay collection expenses and attorney's fees if my account is sent to the collection agency or an attorney for collection.
9. To pay for my refraction expense if my insurance does not cover.

Date: _____ Signature: _____