FINANCIAL POLICY

We may bill your insurance company as a courtesy to you. Please provide your current Insurance Information.

You are responsible to pay the estimated balance your insurance will not cover. This balance is due at the time of service.

The following terms are accepted:

1. Payment for services rendered is due in full on date of service.
2. Payment for materials is due the date of the order.
3. We accept cash, checks, Visa, MasterCard, Discover, and Care Credit.

LIFETIME INSURANCE AUTHORIZATION

I understand Family Eyecare Specialists, PLLC will verify my eligibility and benefit information.

THIS DOES NOT GUARANTEE PAYMENT BY THE INSURANCE COMPANY.

I request that payment of authorized benefits from Medicare or other insurances or programs be made either to me or on my behalf to Family Eyecare Specialists, PLLC for any products or services furnished to me.

I also authorize any holder of medical information about me to release any information needed to determine these benefits or benefits for related services.

I undertand that I am financially responsible for all charges whether or not paid by my insurance company.

Patient: ____

Guarantor: ______________________ Relationship: ______________________

Date: ______________________

PATIENT ACKNOWLEDGEMENT
RECEIPT OF PRIVACY, OFFICE AND FINANCIAL POLICIES

I have received and read a copy of the "Notice of Privacy Policy" of this office and understand my rights regarding my Protected Health Information (PHI) according to the rules and regulations set forth by the Health Insurance Portability and Accountability Act (HIPAA).

______________________________ ______________________
Patient/Guardian Signature Date

______________________________ ______________________
Witness Date