Patient Financial Responsibility Disclosure Statement

Medical Insurance

We have contracts with many insurance companies. We will bill them as a service for you. As the *Patient* or *Responsible Party*, you are responsible for any balance if your insurance company refuses to pay for any reason. The person signing on behalf of the *Patient* as the *Responsible Party* must:

Please check off the following:

- ☐ Inform The Eye Center at Jackson of the current address and/or phone number for the *Patient* and *Responsible Party*.
- ☐ Present all current insurance cards (Vision and Medical) prior to each visit.
- ☐ Pay any required co-pay at the time of visit.
- ☐ Pay any additional amount owing within 30 days of receiving a statement from our office.
- ☐ Pay any required insurance deductible.
- ☐ Please note refractions (The test to ensure your vision through your glasses is at its best) are not covered by most insurances. Therefore we will collect $45. Please note a refraction costs $90 and we are offering you a 50% discount if paid at the time of your visit. If your insurance reimburses us, we will gladly reimburse you. If you decline to pay this fee at the time of your visit and the insurance company denies your claim, you will be charged the original $90.
- ☐ I also understand that certain procedures such as the Optomap /Retinal Scan, Corneal Scan and Contact Lens Fitting are patient "elective" procedures and I will pay at the time of service the cost as it is not covered by insurance.

Non-Payment on Account

Should ***Collection*** proceedings or other legal action become necessary to collect overdue amount, the patient's *Responsible Party* should understand that The Eye Center at Jackson has the right to disclose to an outside *Collection Agency* all relevant personal and account information necessary to collect payment for services rendered. The *Patient* or patient's *Responsible Party* understands that they are responsible for all costs of collection costs and attorney fees, in addition to their outstanding balance. By signing below, you agree to accept full financial responsibility as a *Patient* who is receiving medical and/or vision services or as the *Responsible Party* for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities and agree to these terms.

_____ _____

Print Patient Name Date

_____ _____

Print Responsible Party Name Date

_____ _____

Signature Responsible Party Date