CY-FAIR EYECARE FINANCIAL RESPONSIBILITY FORM

CY-FAIR EYECARE FINANCIAL POLICY

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

Unless other arrangements have been made in advance by either you or your health coverage carrier, full payment is due at the time of service. For your convenience we accept most major credit cards and cash.

YOUR INSURANCE MEDICAL:_____ VISION:_____

We have made prior arrangements with many insurers and other health plans. We will bill those plans with which we have an agreement and will collect any required copayment at the time of service. The copayment will be collected when you arrive for your appointment. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. In that event we will bill you, and payment is due upon receipt of that statement.

If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you, on an unassigned basis. In this case, your insurer will send the payment directly to you. Therefore charges for your care and treatment are due at the time of service.

We will also bill your health plan for all services that we provide in the hospital. Any balance due or non covered services is your responsibility and is due upon receipt of a statement from our office.

MINOR PATIENTS

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____ _____

Signature of Patient or Responsible Party if a Minor Date

_____

Signature of Co-responsible Party

_____

Please print the name of the Patient