Premier GLAUCOMA & Eye Center

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PATIENT FINANCIAL RESPONSIBILITY DISCLOSURE & AGREEMENT

The purpose of this disclosure and agreement is to make you aware that you are financially responsible for your bill for medical services rendered to you by Premier Glaucoma & Eye Center. Quality eye care is our primary goal, and our office does not wish to cause undue hardship for any of our patients. Should a financial hardship exist, our office will discuss alternative payment methods on an individual basis.

Please be aware:

- You are responsible for payment of all charges, regardless of the status of any insurance claim. Rejection or reduction of your claim by your insurance company does not relieve you of your financial responsibility.
- Your insurance policy is a contract between you and your insurance company. We do not accept the responsibility of negotiating claim disputes for you.
- Co-payments and deductibles, as well as charges for refraction and other non-covered services will be collected at the time of the office visit.
- All balances over 60 days from service may be subject to a $5 rebilling fee.
- Returned checks are subject to a $25 fee.
- Refraction Fees: A $40 Refraction fee is a necessary part of your eye exam.
    - A refraction is a test generally used to determine how well a person sees. Refractions may be necessary for the physician to diagnose your eye condition. If you have a medical problem, your visit must be billed to your medical insurance and you may still need a refraction. Unfortunately, refractions are not covered by some insurances, such as Medicare, even if a patient has glaucoma, cataracts, etc.

Our no-show policy is as follows:

- A 24-hour notice is required if you are unable to keep your appointment.
- After the first no-show appointment you will receive a phone call to remind you of the missed appointment and to reschedule your appointment.
- After the second no-show you may be charged $50 for the time slot we were not able to fill when you were a no-show.

We want your experience with Premier Glaucoma & Eye Center to be a positive one, and our office will be happy to help you with your medical and financial concerns.

I do hereby guarantee unto Premier Glaucoma & Eye Center, the prompt payment of all bills incurred by me or my dependent patient and any costs as indicated above.

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Printed Name of Patient Date

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Signature of Patient or Responsible Party