Premier GLAUCOMA & Eye Center

1160 S. Linden Rd
Flint, MI 48532
810-820-8230
Fax: 810-820-8937
www.premierglaucoma.com

Patient Financial Responsibility and Consent to Treat Agreement

Financial Agreement: I agree that in return for services provided to the patient by **Premier Glaucoma & Eye Center,** I will pay my account at the time of service or make financial arrangements to satisfy this debt. I recognize that my insurance policy is a contract between me and my insurance company and therefore, it is my responsibility to pay any co-pays, deductibles, and/or coinsurances designated by my insurance company. I recognize that it is not the responsibility of **Premier Glaucoma & Eye Center** to negotiate the aforementioned fees or claims disputes on my behalf. I authorize **Premier Glaucoma & Eye Center** to bill my insurance for services rendered as well as share any required clinical information with my insurance in order to facilitate claim processing. I authorize my insurance benefits to be paid directly to the undersigned or to **Premier Glaucoma & Eye Center.**

No-Show Policy:

- A 24-hour notice is required if you are unable to attend your scheduled appointment
- After the first no-show you will receive a phone call to remind you of your 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.

Privacy Policy: I understand that I may receive a copy of **Premier Glaucoma & Eye Center's** privacy plan upon my request.

Permission to Treat: I, _____, as the patient or parent/guardian of the patient do hereby give **Premier Glaucoma & Eye Center** permission to treat _____ for any vision or other problems related to his/her eyes using whatever ophthalmic testing and treatments deemed medically necessary. This permission is valid for one year form the date on this form.

Minor Children: I understand that as the parent or guardian of the minor patient, I am responsible for any fees that may result from services rendered by **Premier Glaucoma & Eye Center**. I also understand that I may be asked to submit proof of foster care and/or guardianship if I am not the legal parent of the minor patient.

Patient's Name: _____ **D.O.B** _____

Responsible Party's Name: _____ **D.O.B** _____

Address: _____ **Phone:** _____-_____

Street City State Zip

Patient or Responsible Party's Signature: _____ **Date:** _____