DISEASES AND SURGERY OF THE EYE

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PATIENT RESPONSIBILITIES

I, the undersigned, in consideration for services being rendered to the patients by Associates in Eyecare, P.C., understand and agree to the following:

1. I understand that payment for charges, including co-payments, coinsurance, deductibles and non-covered refractions are due on the date of services are rendered.

2. I Hereby authorize Associates in Eyecare, P.C. to file with my insurance carrier and I assign payment of medical benefits to Associates in Eyecare.
   P.C.

3. I will keep my account current as to charges for which I am responsible, in the event I fail to pay charges, Associates in Eyecare, P.C. is entitled to take whatever action necessary to collect such charges and I will be responsible for fees incurred as a result of such collection.

4. I authorize release of any and all medical records and information necessary for continuation of care and for processing any claims associated with services I receive in this office.

5. I understand that my insurance benefits and referral requirements are my responsibility. Associates in Eyecare, P.C. will assist me in any areas possible, but ultimately, I am responsible to understand my benefits and obtain any referrals necessary.

6. I will be sure to inform Associates in Eyecare, P.C. anytime my personal information about insurance coverage changes.

7. The patient hereby acknowledges and agrees that any account that becomes delinquent will be forwarded to a collection service. In the event of default, I agree to pay all collection agency fees 50% on top of outstanding balance and any attorney fees associated with the collection agency. I hereby authorize this provider and its agents, and assignees to contact me via email and phone calls to obtain any balance due.

My signature below indicates that I acknowledge and agree to the set terms above.

Patient Signature: _____ **Date:**_____