PALMETTO CATARACT & EYE SPECIALISTS

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Palmetto Cataract and Eye Specialists as your healthcare provider. We ask that you carefully read and sign this form to acknowledge your understanding of our patient financial policies.

PATIENT FINANCIAL RESPONSIBILITIES:

(1) The patient (or patient's guarantor, if a minor) is ultimately responsible for the payment for medical services rendered.

(2) I understand that it is my responsibility to supply Palmetto Cataract and Eye Specialists LLC with any current insurance information and/or any referral authorization forms (pre-authorization forms).

(3) Patients (or guarantors) are responsible for payment of co-pays, co-insurance, deductibles, supplemental fees, and all other fees not covered by their insurance plans. Payment must be paid at the time services are rendered. This is necessary in order for us to bill your insurance carrier on your behalf for your convenience.

(4) I authorize Palmetto Cataract and Eye Specialists LLC to release any information necessary to insurance carriers regarding my illness and treatments to process insurance claims.

(5) I hereby assign all medical and surgical benefits to which I am entitled (assignment of benefits). I authorize and direct my insurance carrier(s) to issue payment check(s) directly to Palmetto Cataract and Eye Specialists LLC for rendered services. If I receive payment check(s) from my insurance carriers, I will promptly forward them to Palmetto Cataract and Eye Specialists LLC.

(6) We will file your claim for services rendered with your insurance carrier and allow 30 days for payment in full. If payment is not received within 30 days, the balance due will become the obligation of the patient or guarantor (responsible party) and must be paid within 30 days.

(7) If you do not have insurance or we are non-participating providers with your insurance carrier, payment is expected at the time services are rendered.

(8) I understand that if I have a routine (non-medical) diagnosis, my insurance may not cover the cost of the exam. I understand that Medicare and most insurance plans do NOT cover standard care, refraction fees (fees vary), or contact lens exams (fees vary) and that I will be fully responsible for these charges.

(9) I understand that I will be responsible for payment for non-covered services (as deemed by your insurance company).

(10) If this account results in collection agency involvement, the undersigned patient or guarantor agrees to pay all legally allowed interest and associated fees.

(11) Payments may be made by cash, check, or credit card (Visa, Discover, Mastercard, or American Express).

(12) This authorization will remain on file for future rendered services.

I UNDERSTAND THE ABOVE FINANCIAL RESPONSIBILITIES AND AGREE TO THEIR TERMS. I ALLOW A PHOTOCOPY OF MY SIGNATURE TO BE USED TO PROCESS INSURANCE CLAIMS.

Signature of Patient or Guarantor: _____

Print Patient's Name: _____ Date: / /

Print Legal Guardian's Name, if applicable: _____