EYE CENTERS

OF NORTHWEST OHIO LLC

Patient Name: ___________________________ **Patient ID:** ________________ **Date:** ___________

Patient Financial Responsibility Contract

Please read, initial each blank and sign where indicate. This document is a description of your financial responsibilities.

___ (Initial) I agree to be financially responsible for payment of services rendered by Eye Centers of Northwest Ohio, LLC. Cash, check, or credit cards are acceptable forms of payment for these services.

___ (Initial) Current insurance cards must be presented at every office visit. Eye Centers of Northwest Ohio, LLC. is not responsible for filing your insurance claim, but will do so as a courtesy. I agree to pay the remaining balance after my insurance has paid on my claim upon receipt of a statement.

___ (Initial) I agree to give Eye Centers of Northwest Ohio, LLC. my complete and accurate insurance information for primary and secondary insurance benefits, including referral documents from other providers, if needed. I understand that if I fail to give complete and accurate information about my insurance benefits, this may result in a denial of my claim or a delay in payment. I agree to pay Eye Centers of Northwest Ohio, LLC. the balance on my account after my insurance claim has been processed.

___ (Initial) I understand there will be a $30.00 fee for all returned checks.

___ (Initial) I understand that my insurance may or may not agree to the usual, customary or reasonable charges for my local area. I understand that my benefits may not cover all services. I agree to pay the balance remaining on my account after insurance has been processed.

___ (Initial) If I have a high deductible policy or do not currently have insurance benefits, I agree to pay an estimate of charges for my office visit in advance, and understand that other charges may apply.

___ (Initial) Eye Centers of Northwest Ohio, LLC. has a contract with my insurance company , and will receive payments for covered services provided by my insurance benefits. I agree to co-payments and deductibles at the time of service.   I understand if I cannot pay co-payments at the time of service, my appointment may be rescheduled.

___ (Initial) If my account becomes delinquent, it may be forwarded to an outside collection agency. If this happens, I understand I will not be able to receive services until active payments are resumed.

___ (Initial) If the reason for my appointment is related to a work injury or auto accident, I agree to give Eye Centers of Northwest Ohio, LLC. the case number or policy number, the workman's compensation or insurance carrier's name, address or other contact information at the time of my appointment so that Eye Centers of Northwest Ohio, LLC can bill workman's compensation or the auto insurance carrier for my visit. If I do not provide this information at the time of the visit, I agree to pay all charges for my visit.

I have read and understand Eye Centers of Northwest Ohio, LLC's. financial policies and I accept responsibility for the payment of any fees associated with my care.

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Patient Signature   Date