Bogan Eyecare Center Financial Responsibilities & Consent

Patient Name: _____ **DOB:** _____

Financial Responsibilities

You (or your legal guardian) are responsible for the payment of your account including payment of copays, coinsurance, all other procedures or treatment not covered by his/her insurance plan and all direct or indirect fees incurred in collecting any outstanding balance.

While we assist in filing for insurance, we cannot guarantee coverage. As the insured, you are responsible for knowing your insurance benefits and requirements for coverage and ensuring that any necessary referrals or authorizations are obtained before receiving services. In the event of a dispute or rejection of a claim you are responsible for payment.

We may file most types of insurance for you as a courtesy, however you are responsible for staying in contact with the insurance company to assure that they pay in a timely manner. We may require payment for your services in full if your insurance company has not paid the benefits to us within 90 days of submission. Any insurance benefits that are later received for those services will be refunded to you. Payment is due at the time of service. Optical products such as eyeglasses and contact lenses require a deposit at the time of ordering and the balance paid at the time of dispensing. We accept cash, check, Visa, Mastercard, and Discover credit or debit cards. In addition, we offer outside financing available through Care Credit. Please ask for details if you have any questions about our Care Credit program.

Cancelled Appointments

While we understand that there may be a time when you miss an appointment due to an emergency or obligation, we ask that you give us 24 hours notice on all cancelled appointments. If you repeatedly miss appointments without any notification you will only be seen on a walk-in, space available basis or will be required to pay a 50% deposit for your eye exam in advance and payment will be forfeited if you do not show. Insurance does not cover missed appointments.

Acknowledgments

*I have read, understand, and agree to the policies outlined above.
*I consent to the performing of optometric services agreed to be necessary or advisable.
*I authorize the release of any information contained in my medical records for the purpose of my treatment, billing, and processing of insurance claims and I authorize payment of benefits to Bogan Eyecare Center.
*I acknowledge that a copy of the Bogan Eyecare Center Notice of Privacy Practices has been made available to me to view.
*The duration of this document is indefinite and continues until revoked in writing.
*I agree that if my account becomes delinquent and turned over to a collection agency, any interest charges that can be added at the current legal rate, collection fees, as well as reasonable attorney fees and court costs will become my responsibility.

_____ _____
Patient's or Parent/Guardian's Name (Print) Relation to Patient

_____ _____
Patient's or Parent/Guardian's Signature Date