# Patient Financial Responsibility Statement
# And Assignment of Health Plan Benefits

Our primary mission is to provide you with quality, cost effective, vision care. Together we are trying to adapt to the changing way that health care is financed and delivered.

- If you are not insured, or if the services being provided are not covered by your insurance, you will be expected to provide payment in full for our services at the time they are rendered.

- It is important for you to understand what your insurance policy covers and does not cover. We are not responsible for any limitations in coverage that may be included in your plan. We deal with dozens of medical plans and scores of vision plans and each plan is different; therefore, it is impossible for our staff to precisely know all the details of your plan. Additionally, some plans are worded poorly making them difficult to interpret. If you have questions regarding you insurance, please call the member services number you were provided on enrollment or listed on your insurance card.

- You must pay any co-payment and applicable deductible amounts at the time of service. Sometimes these amounts are not known until after the claim has been processed by your insurance company in which case we will send you a bill for any amount due. Prompt payment is expected. The remainder of your bill will be sent to your health plan for direct payment to our office. If, by mistake, your insurance plan remits payment to you, please call us for instructions on how to proceed.

Your insurance plan may refuse payment of a claim for some of the following reasons:

1) You have not met your calendar year deductible
2) The health/vision plan was not in effect at the time of service
3) You have other insurance which is primary to the insurance you provided
4) A referral was required for services to be provided
5) The insurance company screwed up

- If your plan denies the claim for any of these or other reasons and no subsequent remedies are available, our office cannot be responsible for your bill. We will assist you in attempting to fix any error or miscommunication with your insurance company, but any dispute on coverage or benefits is between you and them. It is your responsibility as a patient to pay us the denied amounts in full.

- Failure to make full payment on your account will force us to dismiss you from our practice and your account will be turned over to an outside collection agency and your information reported to the credit bureaus. Please note that we have a $$$ fee on all checks returned for nonsufficient funds.

- Financing is available through Care Credit. Ask our staff for information on applying.

Again, we value you as a patient and our first priority is to provide you with the best possible care.

***I have read and understand my obligations and I acknowledge that I am fully responsible for payment of any services not covered or approved by my insurance carrier. I also hereby authorize payment of any health/vision plan benefits directly to Gary Duey, O.D. d/b/a Focus On Vision for services that have been or will be rendered. If applicable, I also authorize the release of information contained in my records that is needed to file and process insurance plan claims. The notices contained in this document will remain in effect unless revoked in writing and a photocopy or scan is to be considered as valid and enforceable as a paper original.***

Signature of Patient or Responsible Party Date

Printed Name and Printed Name of Patient (*if different)*