URBAN EYES

BILLING AND FINANCIAL POLICIES

Insurance Authorization and Assignment: I authorize ***Urban Eyes*** to furnish information concerning my visit to my insurance carrier and assign to the provider all insurance payment for medical/vision services rendered on my behalf.

All services are the Responsibility of the patient: I understand that verification of insurance eligibility and benefits is not a guarantee for payment, and that payment of insurance benefits is determined only when the claim is processed by the insurance carrier. I understand that when my insurance company requires a referral from my primary-care physician, and I do not furnish the correct referral at the time of service, I will be responsible for payment if my insurance company refuses my claim. I also understand and acknowledge that I am financially responsible for non-covered services and any unpaid insurance balance.

Payments, Co-pays and Deductibles are Due at Time of Service: I understand that not all services and materials may be covered by my insurance or may exceed benefits or coverage. I agree to pay all payments, co-pays and deductibles at the time of service for all services and materials.

Returned Checks: There is a $25.00 fee for any check returned by the bank. This fee will be added to the unpaid balance and must be paid by cash.

Patient's Name:_____ (please print)

Responsible Party
(if not the patient):_____ (please print)

Signature: _____ Date:_____