Patient Name: _____
DOB: _____

Eye Physicians and Surgeons Financial and Privacy Policy

Full payment for service(s) is due at the time of service(s). We accept cash, checks, Visa, MasterCard, and Discover.

- I request payment of authorized Medicare and/or insurance benefits be made on my behalf to Eye Physicians and Surgeons for any services furnished by them. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, its agents, or any other insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing.

- I understand I am financially responsible for all charges not covered by my insurance, and all co-pays and deductibles are due at the time of service. I also understand an additional fee of $25.00 will be charged for all returned checks.

- Medical insurances (example: Medicare) do not pay for the examination required for glasses and contacts (**REFRACTION**). I agree to be personally and fully responsible for payment.

- If my health insurance requires prior approval or a referral for services, I understand it is my responsibility to obtain it prior to the day of my appointment. If the referral is not received by Eye Physicians and Surgeons, I understand my appointment may be cancelled until such time it is received or I will be responsible for any fees associated with the office visit.

- I understand a legal guardian **MUST** accompany minors at their initial visit and an adult at all subsequent visits. The legal guardian is responsible for full payment of services at the time of treatment.

- This office is **NOT** a party to your divorce decree. The legal guardian who accompanies the minor at the initial visit is responsible for payment.

- I authorize Eye Physicians and Surgeons to communicate with me by phone, answering machine, letter, or email at my home or business regarding appointments, care, or billing.

- I agree to the release of my medical information to my personal physician(s) or optometrist(s).

- I give permission to discuss my medical information with the specific individuals named below (examples: spouse, adult children, caregiver, emergency contact). I understand it is my responsibility to update this list in order to keep accurate those authorized persons to receive or use my healthcare information.

  1. _____ 2. _____

  3. _____ 4. _____

- I acknowledge a copy of Eye Physicians and Surgeons Notice of Privacy Practices is available for my review and a copy will be provided at my request.

Signature (Patient/Legal Guardian): _____ Date: _____