Dr. David R. Gore, O.D., PC

Office Financial Responsibility

Welcome to our office. To better help serve you, please read and sign the following financial responsibility:

1. Payment in full is due at the time of service. We accept cash, check. Visa, Master Card, American Express, Discover and Apple Pay.
2. All checks returned by the bank for insufficient funds will incur a $25.00 bank and administrative fee. We will notify you about your returned check and your $25.00 fee so you can pay your balance.
3. Your appointment time is reserved exclusively for you. We require 24 hour notice for cancellations. There is a $50.00 charge for a missed appointment without 24 hour notice.
4. Balances 30 days past due are subject to a $10.00 monthly rebilling fee. If this account is turned over to our attorney or collection agency, you agree to pay all fees including court costs and added interest from the initial statement date.
5. Patients who need referrals are responsible for arriving with them or will be responsible for paying services in full.
6. All patients wearing contact lenses receive additional tests and follow up care above and beyond a comprehensive eye exam. This is referred to as a "Contact Lens Medical Evaluation" and is performed on all patients wearing contact lenses every 12 months whether or not new contact lenses are purchased. There is an additional charge for this service. Most insurance plans do not cover contact lens related charges. If you are no longer interested in wearing contacts, please inform our staff and remove your contact lenses before the examination begins. However, we will not be able to dispense any more contact lenses, write a prescription for contact lenses, or be responsible for your contact lens exam.
7. As your provider, it is our responsibility to provide you and your family with the best possible care. Please remember, your insurance policy is between you and your insurance company, and not between your insurance company and us. For our insurance patients:

   *Please present insurance information at time of visit. It is your responsibility to provide us with the proper information we need to verify your benefits and process your claim. Our office will not accept your insurance after the visit. Please be aware that each insurance company has dozens of plans, all a little different. It is impossible for our staff to have complete knowledge of each one. We will do our best to quote your portion of the bill when you are here. Note, as your insurance company tells us, they will not guarantee paying their quoted amount until they personally process your claim. In the event that we receive more payment then expected, you will be refunded. However, if there remains a balance due, you are responsible for all charges.

   If there are any questions please ask us. Please sign below to indicate that you have read, understand and agree with the above policies.

Signature_____Date_____

Name of Policy Holder on Insurance _____

Policy Holder's DOB: _____

Patient relation to Policy Holder (self, spouse, child, etc.): _____

Medical information may be released to:_____