Financial Policy Agreement

This information pertains to payment for services for all patients
With or without medical insurance or vision benefits. (Signature required)

I understand that I am financially responsible for all fees for professional services and/or materials on the day services are rendered. If I have medical insurance or vision benefits herein referred to as "Benefits Carrier" I agree to assign directly to American Eye Care Centers Inc. dba Eye Doctor's Office & Eye Gallery, Inc and / or Dr. Bob Consor, Dr. Crystal Eylar, herein collectively referred to as "The Provider" are inadvertently paid to me I agree to reimburse or forward such payment directly to "The Provider" in a timely manner.

I understand that authorizations from the Benefits Carrier to The Provider are not a guarantee of payment. I acknowledge that I am financially responsible to pay all applicable deductible or co-payments on the day of service and any additional fees for services or materials that are deemed my responsibility by my Benefits Carrier. This information will be notes on the Explanation of Benefits (EOB) form sent by my Benefits Carrier to the Provider and me after the day of service.

After The Provider timely files my benefits claim, and the EOB is received from the Benefits Carrier, I agree to pay all unpaid balances that I am responsible for as noted on the EOB as "patient's responsibility", including unmet deductibles, co-payments or non-covered materials or professional services. In the event that my benefits carrier denies payment of my claim, I agree to pay in full to The Provider all outstanding balances.

I further authorize The Provider to charge my credit or debit card on file with this office for those fees and I expect to receive an accounting in the mail within 72 hours.

- If you don't inform us that you have medical or vision benefits before your office visit, we will assume no coverage exists. With no exceptions we will not back file claims, post authorize claims, or refund any fees after services or materials are rendered.
- We will do our best to pre-authorize your benefits before your office visit, but in the event your Benefits Carrier can't give us accurate or timely authorization, you will be responsible to pay the usual and customary fee for all services and materials the day those services are rendered. No refunds for the difference in usual and customary fees and insurance adjusted fees will be made to you thereafter.
- You will be responsible to file your own benefits claim if we are unable to get your Benefits carrier to authorize your benefits after we give it our best effort. We will make every effort to assist you in getting the benefits you deserve.

I have read this document, have had an opportunity to ask questions and received answers to my satisfaction. I understand and agree to the terms of this agreement.

X _____ _____/_____/_____

Patient or Guardian Signature Date