Roger's Regional Eye Center

Statement of Financial Responsibility

Patient Name: _____

1. I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical service or visit, routine examination, refraction, testing, contact lens services and any other screening ordered by the doctor or staff.
2. I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.
3. I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full at the time of service.
4. I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.
5. If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID card and my secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will then be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

By signing below I am acknowledging that I have read the Statement of Financial Responsibility and understand and agree to these terms.

Patient Signature: _____ **Date:** _____