

PATIENT FINANCIAL AGREEMENT

I agree that in return for the services provided to the patient by Stuart Eye Institute, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Stuart Eye Institute for payment. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Stuart Eye Institute. All co-payments and past due balances are due and payable at the time of service. I understand and agree that if my account is delinquent, I may be turned over to a collection agency.

NON-COVERED SERVICES

I understand that Stuart Eye Institute contracts with health care service plans (i.e. HMOs, PPOs) that relate only to items and services which are “covered” by the health care service plans. Accordingly, the undersigned accepts full responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient’s contract with a health care service plan, or in the benefit summary the health care plan furnished to the patient.

HMO REFERRALS

If your insurance has designated a primary care physician (PCP), you are required to have prior authorization from your PCP prior to your office visit. If the authorization is not provided, whether by yourself or through your insurance carrier, you will be asked to either reschedule your appointment or pay for your visit at the time of service.

SELF-PAY ACCOUNTS

Self-pay accounts are patients who are covered by carriers that the practice does not participate in, or patients without an insurance card on file or at the time of service. The undersigned agrees that I am individually obligated to pay the full charges at the time of service.

NON-PARTICIPATING INSURANCE ACCOUNTS

The financial obligations of patients who are insured by carriers with which the practice does not participate in are considered a self-pay account. It is your responsibility to inform us of any changes with your insurance carriers, to confirm the practice’s participation, and your eligibility prior to each visit. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Stuart Eye Institute if I belong to a plan in which Stuart Eye Institute does not participate.

RETURNED CHECKS

All returned checks will be assessed a \$20.00 fee.

Signature of Patient or Authorized Party

Date

Signatures by persons 18 years and over.