# EYE CONCERN, INC
## Statement of Financial Responsibility/AOB

The **Eye Concern, Inc.** appreciates the confidence you have shown in choosing us to provide for your prosthetic eye care. We are working to provide the highest quality ocular prosthetic care for your benefit. Any contract we have, therefore, is directly with **you**, the patient. All ocular prosthetic services provided for you in this office are charged directly to you, and you are responsible for payment of such services. We do not render services on the assumption that your charges will be paid by your insurance carrier.

**INSURANCE**
We share a relationship with certain insurance companies. Please ask if your insurance is one of them. We are a ***NON-PARTICIPATING MEDICARE PROVIDER***, and as such are *NOT REQUIRED* to accept Medicare assignment. You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies or takes back any monies provided, you will be fully responsible to resolve the charges in a timely manner.

It is your responsibility to contact your insurance and obtain a pre-authorization (if required), a gap-exception, and/or any other information necessary to be able to receive payment or reimbursement from your insurance. Insurance verification or pre-authorization is not a guarantee of payment for the services you receive. The insurance carrier determines the benefit payments. In the event of denied or delayed insurance claims, payment in full will be your responsibility within sixty (60) days of the date of service. If for any reason we do carry a balance on your account, interest will accrue @ 0.83% per month beginning 30 days from the date of service and will continue until the balance is paid in full.

Please let us know immediately if there is any change in your insurance coverage ***prior*** to your appointment. We are not liable for misdirected claims due to incorrect insurance information. If you do not inform us of any medical insurance ***before*** services are rendered, we will assume no coverage exists. We cannot retro claims, post authorize claims, or refund fees once service has been rendered.

**RETURNED CHECKS**
A service charge of $30 will be applied on all returned checks. If it is not resolved in a timely manner, and is subsequently sent to collections, the amount due may be double the amount of the check plus all collection fees as permitted by law. No post dated checks will be accepted.

**FORM FEES**
Any additional forms brought into the office for us to fill out such as Disability, FMLA forms, Leave of Absence Forms, etc. will be subject to a 25.00 to 50.00 charge. The fee is due at the time the form is presented to the office. The forms will not be filled out until the fee is paid. Please allow up to 7 business days for the completion of the forms.

**MINOR CHILDREN**

If treatment is to be rendered for a minor child, the parents or legal guardian are responsible for payment at the time of service. If someone else is accompanying the child, please be sure they are prepared with the payment at the time of service. If an adult other than the parent/guardian is accompanying the child, they will need to stay in the waiting room during the appointment unless a signed letter is brought in stating that we may discuss the progress of the minor child with them.

**COURTEOUS CARE**
Eye Concern and staff strive to give quality and courteous care. We ask that you please remember sometimes emergencies do arise and your appointment may be delayed. Your patience is greatly appreciated. We will do all we can to meet your expectations. Patients who exhibit abusive language, rude or inappropriate behavior will be asked to leave and seek care elsewhere.

**PATIENT RESPONSIBILITY**
I understand that I am responsible for all costs associated with my ocular prosthetic treatment. After 30 days, any unpaid balances will be assessed interest (0.83% per month) and a late charge of 1.5% of the total balance due each month until the balance is paid in full. Account balances with inactivity after 45 days may be considered delinquent and subject to collections unless prior arrangements have been made. Should my account become delinquent and fees arise from trying to recover this balance, I agree to pay any and all collection fees, court costs and/or attorney fees.

Your signature below acknowledges that you have read, understand and agreed to abide by our office policies.

**YOUR SIGNATURE ON THIS DOCUMENT WILL SERVE AS A SIGNATURE ON FILE FOR ASSIGNMENT OF BENEFITS (AOB) FOR ANY AND ALL SERVICES RENDERED.**

**Patient Name:** _____ **DOB:** _____
(Please Print)

**Signature:** _____ **Date:** _____

**Guarantor Signature:** _____ **Date:** _____
(If Guarantor is not the Patient)