ACKNOWLEDGEMENT OF FINANCIAL POLICY AND PATIENT CONSENT TO TREATMENT

*PLEASE INITIAL TO THE LEFT OF EACH STATEMENT

_____ I understand that payment is due at the time services are rendered unless my doctor contracts with my insurance. All charges not covered by an approved insurance carrier remain my immediate responsibility. If my insurance is contracted I understand that the office may submit my claims to them.

_____ I understand that I am responsible for knowing my co pays and must make any copayments and unmet deductibles at the time of service.

_____ I understand that if I am a Medicare recipient, I am responsible for my deductible and 20 %

_____ I understand that the preferred method of payment is cash or check. Debit and credit cards may be accepted for a balance over $50, with some exceptions.

_____ I understand that a $25 service fee will be charged for all returned checks and that once a check is returned I will need to pay with cash for all future services.

_____ I understand that for insurance claims to be submitted effectively and in a timely manner that I provide a copy of my current insurance card. If claims are rejected because improper information was given to the office, they are my responsibility.

_____ I understand that **all sales are FINAL** and I am not entitled to a refund.

Insurance is a contract between you and your insurance company. We are not a party to this contract. You are responsible for the timely payment of your account.

I hereby authorize my doctor and staff to provide services to me, and hereby consent to the performance of diagnostic procedures, and other treatment as discussed with my doctor. All information that has been provided pertaining to my account is accurate and true to the best of my knowledge.

Print name: ________________________________

Signature: ____ Date: ___/___/____

El Segundo Optometry

Our office is a vision provider for Vision Service Plan (VSP), Medical Eye Services (MES) and EyeMed, and a medical provider for Medicare, Cigna and Blue Cross PPO. It is not the office staff's responsibility to confirm eligibility for services or materials, and the patient or their guardian is responsible for payment of all charges incurred for services received from this office. We do not accept vision plans other than what is listed above. If you have another vision plan services will be out of pocket.

Payment or copayment is due, in cash or check, at the time services are rendered. Debit and credit payments may be accepted when a balance exceeds $50. Exceptions may apply.

If materials are ordered, i.e. glasses and/or contact lenses, a deposit of 50% is required, with the balance due upon delivery. **All sales are FINAL.**

We do not double book appointment. The exam time is set aside for you. In exchange, we ask that you give us 24 hours' notice if you need to cancel or reschedule your appointment. If you do not notify our office to cancel or reschedule an eye exam within 24 hours of the appointment time, a $35 fee will be charged.

I understand and agree to the above statements.

Signature: ____________________________________ Date: ___/___/____