ACKNOWLEGMENT OF FINANCIAL RESPONSIBILITY FOR INSURED PATIENTS

1. I certify that all evidence of health insurance coverage provided by me to Family Eye Care & Surgery is accurate and that my policy is currently in-force.
2. I agree to provide Family Eye Care & Surgery with updates to my health insurance coverage as soon as I am made aware of any changes.
3. I agree that I am responsible for verifying in advance with my health insurance provider the following:
    a. Whether Family Eye Care & Surgery is a participating provider for my plan
    b. Whether Family Eye Care & Surgery is an in-network or out-of-network provider
    c. Covered professional services and insurance benefits provided by my plan
    d. Expenses for which I am responsible including but not limited to co-pays, deductibles, cost sharing, and non-covered professional services
4. I authorize Family Eye Care & Surgery to bill my health insurance provider(s) for professional services.
5. I agree that I am responsible for paying all approved charges by my health insurance provider(s) that are determined to be the patient's responsibility according to the terms of my plan.
6. I agree to pay for all professional services provided by Family Eye Care & Surgery that are not covered by my health insurance provider due to following reasons:
    a. Family Eye Care & Surgery is a non-participating provider in my health insurance plan
    b. Family Eye Care & Surgery is an out-of-network provider in my health insurance plan
    c. The professional service is a non-covered service according to the terms of my insurance plan
    d. My health insurance policy expired before professional services were received

Signature: _____ Date: _____

ACKNOWLEGMENT OF FINANCIAL RESPONSIBILITY FOR SELF-PAY PATIENTS

1. I understand and agree that Family Eye Care & Surgery will bill me for professional services at a rate equivalent to the Medicare allowable rate for my region.
2. I understand that Family Eye Care & Surgery will provide me with an estimated cost of professional services upon request.
3. I accept financial responsibility for and agree to pay for professional services received.
4. I agree that Family Eye Care & Surgery will not bill any health insurance provider for professional services provided to me.

Signature: _____ Date: _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

1. I understand that sharing my personal medical information may be needed in order to process health insurance claims and for the coordination of my healthcare with other medical providers.
2. I authorize Family Eye Care & Surgery to release my personal medical information to:
    a. My health insurance provider(s)
    b. Medical billing companies retained by Family Eye Care & Surgery
    c. Other physicians, medical staff, hospitals, and/or medical facilities involved in my healthcare.

Signature: _____ Date: _____