ASSOCIATES IN EYECARE, P.C.
DISEASES AND SURGERY OF THE EYE

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PATIENT RESPONSIBILITIES

I, the undersigned, in consideration for services being rendered to the patients by **Associates in Eyecare, P.C.**, understand and agree to the following:

1. I understand that payment for charges, including co-payments, deductibles, and non-covered refractions are due on the date services are rendered

2. I hereby authorize Associates in Eyecare, P.C. to file with my insurance carrier and I assign payment of medical benefits to Associates in Eyecare, P.C.

3. I will keep my account current as to charges for which I am responsible, in the event I fail to pay charges, Associates in Eyecare, P.C. is entitled to take whatever action necessary to collect such charges and I will be responsible for fees incurred as a result of such collection.

4. I authorize release of any and all medical records and information necessary for continuation of care and for processing any claims associated with services I receive in this office.

5. I understand that my insurance benefits and referral requirements are my responsibility. Associates in Eyecare, P.C. will assist me in any areas possible, but ultimately, I am responsible to understand my benefits and obtain any referrals necessary.

6. I will be sure to inform Associates in Eyecare, P.C. anytime my personal information of insurance coverage changes.

My signature below indicates that I acknowledge and agree to the set terms above.

Patient/Guardian Signature: _____ Date: ____/____/____