St. Helens Eyecare Specialists Provider Patient Disclaimer

I, the undersigned, hereby authorize the Doctor to take visual field tests/laser scans, photographs, or any diagnostic aids he/she deems appropriate to make a thorough diagnosis of my vision needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I authorize and consent that the Doctor employ any such assistance as he/she deems appropriate.

I understand that I am personally responsible for payment of all fees for vision services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for arrangements including any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangement for payment must be made before treatment begins. Past due accounts over 60 days are charged a late fee of 1.5% per 60 day period (9% per annum). **If assigned to collections, a collection fee of 50% charged by the collection agency will be added to your debt.**

I am aware that it is my responsibility to read and understand my own vision insurance policy, including benefits, limitations and exclusions. I understand that filing of insurance claims is my responsibility and may be provided as a service to me and that any agreement for vision coverage is between my insurance company and myself. I understand that an estimated portion is due at time of service and is estimated according to expected coverage, which may not be disclosed or guaranteed by my insurance company. I understand my portion may be more if my insurance company does not pay the anticipated amount. I also understand that services are rendered independent of insurance reimbursement.

30 day satisfaction guarantee on eyeglasses sunglasses and contact lenses. See our lobby posting or website for details.

Insurance <u>Usually</u> Pays, including but not limited to:
A portion of the Exam, Basic Lenses, & Frame &The choice of glasses or contacts (usually not both)

Patient <u>Usually</u> Pays Extras, including but not limited to:
Progressive/Hi-Index/Glass Lenses, Scratch/AR/ UV Coatings, Photochromic/Tints/Polarized
Drill Mount/Rimless Edging and other options

Patient is Responsible For:
Eligibility Date of Exam and Materials – NOT guaranteed by office staff
Paying Balance of Account that Insurance Does Not Pay
Co-Pays and Extras

I,_____ understand that I am requesting service that may not be approved or covered for payment by my insurance company.

My signature below is my indication that I will personally pay for any services not covered by my insurance company.

_____ _____
Patient or Responsible Party Requesting Services Date Signed