Patient Name___________________ REC Physician________

PCP ____________

DOB ____________

Patient # ____________

Rummel Eye Care, P.C.
Financial Policy

For all patients:

Please be assured that your health is our primary concern. You are responsible for knowing the benefits and restrictions of your Insurance Policy. There are some services provided by this office that may not be covered by your insurance(s). An example of a non-covered service is a REFRACTION.
Payment of your co-payment, remaining deductible, and/or co-insurance is **due at time of service.**
In the event you would need a surgical procedure and your insurance changes between insurance verification and surgery, you are obligated to inform Rummel Eye Care, P.C. of such change. Please understand that any change in insurance may delay surgery.
I have read and understand the above paragraph and hereby acknowledge that any and all medical bills, collection fees on my account, or lawyers' fees incurred due to my delinquent payments are my personal responsibility.

SIGNATURE______________________________ DATE ____________________

Insurance Authorization

I hereby authorize Rummel Eye Care, P.C. to release any medical or other information necessary to file a claim to my insurance company or other payor or agency for collection of Medicare. I authorize payment of benefits to Rummel Eye Care, P.C.

SIGNATURE ______________________________ DATE ____________________

If you do not have insurance

I have no insurance coverage for any health services or vision care services. I understand that I am responsible for any charges related to the services provided to me by Rummel Eye Care, P.C.

SIGNATURE ______________________________ DATE ____________________

*****NOTE: Returned checks are subject to a $20.00 charge*****