Hopping Eye Associates

Patient Financial Responsibility Form

Dear Patient,

In caring for your eyes and vision we provide both medical eye care and routine vision care. Your eye health and vision (how well you are seeing) are intertwined, one affecting the other. Vision insurance primarily covers routine vision (no medical eye condition) and vision correction (glasses and contact lenses) but does not cover your medical eye care if you have a medical eye condition. Therefore, to help you obtain maximum benefits from your insurance, and to keep your costs to a minimum, **we ask that you provide us with both your vision and medical insurance cards before you are seen by the doctor**.

Insurance:

We at Hopping Eye Associates make every effort to verify vision and medical insurance benefits before your appointment; however, verification of benefits is NOT a guarantee of payment. Please be advised that any payment we may or may not collect from you at the time of your visit is based on the verification of your insurance benefits using the information we were provided with by you and your insurance company. Unfortunately, during verification we sometimes find that insurance companies give us incorrect or outdated information. Therefore, initial verification is NOT a guarantee of what you will or will not owe. Once you are seen, a claim will be filed to your insurance company. They will then send us an Explanation of Benefits (EOB). This EOB will show exactly what the patient's financial responsibility is and the amount we are required to bill you.

Explanations:

Please understand that the appointment you are scheduled for was set according to the information that you provided us, or per doctor recommendation from a previous visit. If additional testing or treatment is needed once you are in the exam room, or the exam transitions from a routine visit to a medical eye exam, your fees and financial responsibility may change. We will make every effort to let you know at the time and charge you what is appropriate.

Balance Payment:

I agree that any balance not paid by my insurance company will be paid by me. I agree that my insurance carrier or Medicare may consider some services and/or materials "non-covered"; therefore I will become fully responsible for payment of these services. I also understand that any balance deemed my responsibility that I fail to pay with Hopping Eye Associates, Ltd, LLP may be reported to a credit reporting agency.

I have read and understand the financial responsibility form.

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Patient Name (Please Print) Patient/Guarantor Signature

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Date