Patient Financial Responsibility Statement

Thank you for choosing our practice for your healthcare needs. It is our goal to provide you with the highest quality healthcare services ad possible. We ask that you please read and understand your financial responsibility prior to receiving services.

1. I understand that I am responsible for knowing the policy and provisions and rules of my insurance coverage(s) and that I am solely responsible for obtaining any necessary referrals prior to my appointment. Failure to obtain and present a valid referral may result in my being financially responsible for all services provided. **Please Note: A Doctor's Prescription is Not a valid Referral.**

2. I understand that I am finically responsible for any amount not covered by my insurance including, but not limited to, co-pays, co-insurances, deductibles, and non-covered services.

3. I understand that if I do not have valid insurance, I am financially responsible for all fees, unless other arrangements have been made and all fees are to be paid at the time of the visit.

4. I understand that failure to remit payment for any amounts deemed patient responsibility may result in my account being referred for collection activity and that I will be financially responsible for any additional fees incurred as a result.

5. As a courtesy, and to help patients remember their scheduled appointments, **California Eye Clinic/ Muir Ophthalmology** sends messages and email reminders. If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with the physicial lease give us at least 48 hours' notice. If you do not cancel or reschedule your appointment with at least 48hours' notice, we may assess a **$ 250.00** "no-show" service charge to your account. This "no-show charge" is not reimbursable by your insurance company. You will be billed directly for it. After three consecutive no-shows to your appointment, our practice may decide to terminate its relationship with you. I understand the "no-show" policy of **California Eye Clinic/Muir Ophthalmology** and agree to provide a credit card number, which may be charged **$250.00** for any no-show of a scheduled appointment. I understand that I must cancel or reschedule any appointment at least 48 hours in advance in order to avoid a potential no-show charge to the credit card provided.

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I UNDERSTAND AND AGREE TO THESE TERMS:

Signature of Patient or Guardian **Date**

TURN OVER

Assignment of Benefits

I hereby authorize any insurance carrier, including Medicare, to make payment directly to **California Eye Clinic/ Muir Ophthalmology** for any services rendered to me or my covered dependents of any amounts otherwise payable to me toward the reimbursement of any medical expenses incurred at this facility. **I understand that I am financially responsible for payments of all services regardless of any payment issued by my insurance or not.** A photocopy of his authorization shall be considered as effective and valid as the original.

Signature of Patient or Guardian **Date**

Release of Medical Records and HIPPA Information

I hereby authorize the release of any Protected Healthcare Information (PHI) to any involved insurance company, or their authorized third parties involved in my case unless I have specifically instructed otherwise.

Signature of Patient or Guardian **Date**

Medicare Patients ONLY

I understand that Medicare may not cover certain services. I have been given the **Medicare Advanced Beneficiary Notice of Non-Covered Service (ABN)** which explains my options for procedures that may not be covered by Medicare.

Signature of Patient or Guardian **Date**

California Eye Clinic/ Muir Ophthalmology will keep my credit on file and charge up to $200.00 for any balances that are owed Co-pays, Deductables or Co-insurance. Any amount over the $200.00 I will need to give a verbal consent.

Signature of Patient or Guardian **Date**