

Gainesville Eye Associates Financial Policy

We are committed to providing you with the best possible medical care. If you have special financial needs, we are willing to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services. We will file your insurance as a courtesy to you however, **YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR BILL.**

1. Our office participates with a variety of insurance plans including Medicare and Medicaid. It is your responsibility to:
 - Bring your insurance card at every visit
 - Pay your CO-payment and/or any deductibles at each visit. Payment can be made by cash, check or credit card. We accept Visa, MasterCard, and Discover.
 - Pay in full for any medical care or services that are not covered by your insurance plan.
2. If you have insurance that we do not participate in, our office is happy to file the claim upon request however, payment in full is expected at the time of service.
3. Referrals for HMO, POS, Medicaid or Peachcare: It is your responsibility to bring any required referrals, for treatment prior to the visit. If you do not have a referral, your visit maybe rescheduled or you will be financially responsible for the visit.
4. If the patient is a minor (18 years or younger and not emancipated), the parent or guardian must sign below. The parent or guardian who presents with the minor is responsible for any payment due at the time of service or any remaining balance after insurance pays and bringing the insurance card and/or any referrals.
5. If you have questions about you insurance, we are happy to help you. However, specific coverage issues should be directed to your insurance company member services department. The telephone number should be located on your insurance card.
6. If you fail to make payment arrangements for services that are rendered to you, your outstanding balance will be sent to an out side collection agency.

I have read and understand the above stated financial policy. I accept responsibility for services as outlines above. I authorize the release of medical or any other information to my insurance company. I authorize the release of medical and/or any other information to the Social Security Administration , Health Care Financing Administration and/or it's intermediaries; information needed for this or any other related claim. I permit a copy of this authorization to be used in place of an original and request payments of any medical insurance benefits from my insurance company directly to Gainesville Eye Associates. I understand that I am financially responsible for all charges incurred in care and treatment.

Patient or Parent/Guardian Signature

Date