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A MEMBER OF Vision Source

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Statement of Insurance Authorization and Financial Responsibility

I authorize that payment from my insurance company (ies) be made on my behalf to Union Eye Associates/Owensville Family Eye care for services provided.

I understand that I am to provide accurate insurance information, including medical and vision coverage, upon check-in; inuring that my claims will be submitted correctly.

I understand I will be considered a self-pay patient if my correct coverage is not presented within two business days of my visit.

I agree to pay all remaining responsible charges, after my insurance company (ies) has paid or denied, including but not limited to copays, co-insurance, deductibles and non-covered charges. If you are contracted with my insurance company (ies), you must follow my contract and it's requirements. If I have a co-pay or deductible, I must pay that at the time of service. It is the insurance company that makes the final determination of my eligibility. If my insurance company requires a referral and/or preauthorization, I am responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

I authorize my health information be released to the necessary health agencies, when needed to determine payable benefits.

If no insurance is involved, I understand that I am responsible to pay all fees at the time of services are rendered.

If I default on payment, I understand that I am responsible for all the finance charges, collection fees, and/or attorney fees and court costs. A finance charge will be imposed on each item of my account which has not been paid within thirty (30) days of the time the item was added to the account. The finance charge will be computed at the rate of two percent (2%) per month. The finance charge is computed by applying the thirty days (30) ago, and then subtracting any payments or credits applied during that time. The minimum finance charge is $.50.

Returned checks: There is a fee of $25 for any checks returned by the bank.

Past due accounts: If my account becomes past due, you can take the necessary steps to collect this debt. If you have to refer my account to a collection agency, I agree to pay all of the collection fees which incurred at the rate of 30%.

Waiver of confidentiality: I understand if this account is submitted to a collection agency, the fact that I received treatment at your office may become a matter of public record.

Workers Compensation: You require written approval/authorization by my employer prior to my initial visit. If my claim is denied, I will be responsible for payment in full.

Signature____

Date____