INSIGHT
EYE CARE CENTER

Patient Financial Responsibility Disclosure Statement

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not Insight Eyecare Center. **Note: Most insurance policies pay only a portion of your total charges,** when our office receives an Explanation of Benefits (EOB) from your insurance company, any amounts that show as patient's responsibility will be billed to you. We will do our best to understand your benefits, however sometimes we are unable to gather accurate information from your carrier. If your insurance company has not reimbursed our office in full within 90 days, we will bill you directly for the charges. I authorize the release of any medical or other information necessary to process insurance claims.

The Person signing as the Responsible Party will inform Insight Eyecare Center of: Current address and phone numbers for the patient and responsible party, Present all current insurance cards (Vision and Medical) at each visit, and Pay any required co-pays at each visit.

By signing below, you understand that financial responsibility for your account is ultimately yours as the Patient who is receiving medical and/or vision services or as the Responsible Party for minor patients. Your signature verifies that you have read the above statements, understand your responsibilities, and agree to the terms.

Patient Name (Please Print) _____

Patient Signature / Date _____/____

Responsible Party Name (Please Print) _____

Responsible Party Signature / Date _____/____