MRN#:

T&KEI

TERRY & KIM EYE INSTITUTE

Advancing Eye Care with Research and Compassion

Agreement of Financial Responsibility

Thank you for choosing us as your eye care provider. We are committed to providing quality care and service to all our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Copays are due at the time of service. Co-insurance, deductible, and non-covered items are due 30 days from receipt of billing.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits, any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates, current address, correct phone numbers and changes in coverage. Should you fail to provide this information, you will be financially responsible.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card/s for our records. Patients may incur additional charges for returned checks and we do not accept post-dated checks.

Medical Appointment Cancellation/ No Show Policy

When you schedule an appointment with us we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible (no later than 24 hours prior to your scheduled appointment).

- Any patient who fails to show or cancel/reschedule an appointment and has not contacted our office with **AT LEAST 24 HOURS NOTICE** will be charged a **$25.00 fee**.
- The fee is charged to the patient, not the insurance company and is due at the time of the patient's next visit.
- As a courtesy, when time allows, we send reminder calls, email or text for your appointment. If you don't receive a reminder call/ email/ text or message the above policy will remain in effect.

I have read the financial policies and appointment cancellation/ no show policies contained above, and my signature below serves as acknowledgement of clear understanding of these policies. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full

____ ________________________

Signature of patient/ Responsible party **Date**

____ ________________________

Name of patient/Responsible party (Please Print) **Relationship to patient**