PATIENT FINANCIAL AGREEMENT

Thank you for choosing Specialty Eyecare Group. Our mission is to enrich lives so that others can succeed to their greatest potential. We strive to do this by creating uncompromised service and happiness. In order to make sure that we are all on the same page regarding our financial relationship, we ask that you read and understand the following.

The funds necessary for your eye care treatment are ultimately your responsibility.

FOR THE PATIENTS WITH CLAIMS THAT WILL BE BILLED TO THEIR MEDICAL OR VISION INSURANCE PLAN: Your insurance is a contract between you and your insurance company and not between Specialty Eyecare Group and the insurance company. Acceptance of insurance assignment by our office does not absolve you of your responsibility for the charges for the treatment we provide to you. In most cases, we will attempt to provide you an estimate of the charges for the services that we provide in order to serve as a guideline until final insurance payment is received and your financial account has been reconciled. We can make no guarantees of the insurance payment. If your insurance does not pay for a procedure or informs us that your copayment or deductible is more than what we had initially charged at the time of your visit, you are responsible for payment in full. If there are any discrepancies please contact your insurance company and/or your employer's benefit department.

IF YOU HAVE A DEDUCTIBLE that has not been met, we will collect for the service that we perform on the day of the visit. Your insurance will still be billed so that the service will count towards your deductible.

Accounts that are outstanding for 60 days or more may be subject to a 18% interest charge.

In the event that your balance is sent to the collection agency, you are responsible for full payment of your account to the collection agency. You will also be responsible for any interest, late charges or fees related to collecting of your balance.

Specialty Eyecare Group charges $75 for returned checks.

A fee of $75 is charged for patients who miss or cancel an appointment without a 24 hour notice. We are in a service industry and our appointment slots are how we serve patients. If you cancel your appointment it means we don't get to serve someone else, unless we have enough notice.

I understand and agree to take full responsibility as outlined in this financial agreement for the patient listed below. Any termination of this agreement may only be done in writing and will not apply to any action in process.

________________________	__________________________	________
Patient Name (please print)	Patient/Guardian Signature	Date