
***Let Us Take the Headache Out of Billing Insurance!***

In most cases, our patients wish for us to file their insurance claim on their behalf, and we are very happy to do so. In order to make filing fast, accurate, and in compliance with state and federal regulations, our office has implemented the following policies, which have become standard practice in most local medical practices:

In order for us to file your claim, we must collect all deductibles, co-pays, co-insurance, and fees for services not covered by insurance. Paying these charges when services are rendered will help us lower the chances that your claim will be denied.

If your insurance company requires a referral from another physician in order to cover your visit, you are responsible for obtaining one prior to scheduling an appointment with us.

We will file your claim for your office visit or surgery with your insurance company and allow 30 days for payment in full. If payment is not received within 30 days the balance due will become the obligation of the person you identify as the responsible party. If you do not have insurance or we are not a participating provider with your carrier, payment is expected at the time that services are rendered.

**Agreement to Pay**

The undersigned guarantor hereby accepts financial responsibility for all charges rendered to the patient. This includes the deductible, co-payments, co-insurance, and supplemental fees that insurance carriers typically don't cover such as the $40 refraction fee and a $25 no-show fee. These can be paid by cash, check, Visa, MasterCard, and American Express.

I understand that I am to forward any payment that I may receive from my insurance carrier for services rendered by Winter Park Ophthalmology. This is known as Assignment of Benefits. If the insured's carrier does not remit payment within thirty days, the balance will be due in full from me.

I understand the above Agreement to Pay and have been given the opportunity to ask questions about it. I agree to meet my obligation for charges incurred.

Printed Name of Patient _____ Date of Birth _____

Signature of Patient or Responsible Party _____ Date _____