eyes on hayden.

Statement of Financial Responsibility

In order for Eyes on Hayden to service my account or to collect any amounts I may owe, I agree that I may be contacted at any phone number or address I have provided today or during previous/future encounters.

If I am self-pay, I understand that fee for services is due at time of service. I understand that if going through insurance, my co-payments and fees for elective services are also due at time of service.

Elective services offered during a routine eye exam may include:

- Refraction (if not covered by insurance)
- Contact Lens Evaluation
- Wellness Photo and/or Scan
- Optimized Peripheral Vision Testing

I agree and understand that my glasses and/or contact lenses and the associated prescriptions may not be released if there is an unpaid balance. I also understand that fee for services are non-refundable and non-negotiable, and that glasses and contact lens prescriptions released from our office are valid for one year.

I furthermore agree to pay any collection expenses incurred to collect any amount I may owe due to non-payment. I understand that I am solely responsible for the cost of all non-covered items, as outlined in detail on my receipt which includes: the specific date of service, description of each procedure/service, materials, and the amount I am responsible for paying out-of-pocket; I certify that I have been informed of all items and associated costs.

I authorize the release of my information for my eyecare provider to file all insurance claims Eyes on Hayden is a participating provider for. I understand however, that there is no guarantee of benefit information and/or coverage; if my insurance denies payment for any claims submitted, I will be responsible for full payment and can contact my insurance company directly should there be a dispute. I also understand that my eyecare provider will supply me with an itemized statement which I may submit to my insurance carrier should I need to submit for reimbursement.

I understand that any follow-up appointments related to a contact lens evaluation are included for 60 days after the initial fitting. Should there be any follow-up appointments required after the initial 60 days, I am responsible to pay the associated professional service fee.

Should I receive a medical examination, I understand that my major medical insurance will be billed and I will be responsible for any deductibles, coinsurance or copayments that may be due.

I,_____ (print patient name) have read and reviewed Eyes on Hayden's Statement of Financial Responsibility and agree to the above terms.

_____ _____

Signature of Patient (or: □ Parent □ Guardian) Date: