# IMPORTANT NOTICE

PLEASE BE AWARE THAT REGARDLESS THE TYPE OF INSURANCE YOU MAY CARRY, YOU ARE ULTIMATELY RESPONSIBLE FOR THE ENTIRE CHARGES, IF YOUR INSURANCE DENIES ANY OF THE SERVICES THAT YOU RECEIVED, YOU ARE ULTIMATELY RESPONSIBLE AND WILL BE BILLED DIRECTLY.

FAILURE TO PAY YOUR BALANCE IN TIMELY MANNER WILL RESULT IN SUSPENDING YOUR PRIVILEDGES AS A PATIENT AND SENDING YOUR ENTIRE INFORMATION TO COLLECTION AGENCY. WE VIGOUROUSLY FOLLOW THIS POLICY AND THERE IS ABSOLUTELY NO EXCPETIONS.

BY SIGNING BELOW YOU AGREE TO OUR TERMS OF SERVICE. FAILURE TO SIGN THIS SHEET WILL TERMINATE OUR RELATIONSHIP AND YOU NO LONGER ARE CONSIDERED A PATIENT AT THIS CLINIC.

_____ _____

NAME OF PATIENT DATE

_____

SIGNATURE OF PATIENT

# Palm Coast Eye Physicians, LLC
## Financial Policy

We require payment in full, which is due at the time of service, unless we participate with your insurance company, or prior arrangements have been made. **You are ultimately responsible for payment and knowing what is not covered by your insurance policy. If you have an HMO, you are responsible for confirming that we have authorization to see you prior to all of your appointments.** We will file claims with non-participating and secondary insurance companies as well. However, payment for all services will revert back to the patient if non-contractual insurance payments are not made to this office within 30 days of the claim being filed. We collect all co-payments, co-insurances, and deductibles at the time of service. We accept Cash, Checks, and Major Credit/Debit cards. Please note that you may incur a $40.00 fee for any returned checks.

### Missed Appointments:
You may be subject to a $50.00 charge for missed appointments if appointments are not cancelled at least 24 business hours in advance. Same day cancellation charge is also $50.00.

### Insurance Changes:
Please notify us prior to your next visit if your insurance changes or you may be held responsible for payment.

### Financial Agreement:
The undersigned agrees that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the physician(s) in accordance with the regular rates and term of the physician(s). Should the account be referred to an attorney for collection, the undersigned shall pay all attorney fees and all collection expenses.

## Assignment & Release

I, the undersigned, have insurance coverage with _____
Name of Insurance Company

And assign directly to the Palm Coast Eye Physicians all medical benefits, if any, otherwise payable to me for the services rendered. ***I understand that I am financially responsible for all charges whether or not paid by insurance (within the practices and contractual agreement).*** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature of all my insurance submission.

## Medicare Authorization:
I request that payment of authorized Medicare benefit to be made either to me or on my behalf to Dr. Pourkesali of Palm Coast Eye Physicians for any services furnished to me. I authorize any holder of medical information about me to release to Palm Coast Eye Physicians Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in the item 9 of the CMS-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare Carrier.

**PLEASE SIGN THIS ASSIGNMENT OF BENEFITS & FINANCIAL POLICY/AGREEMENT**

_____ _____

**Signature of Patient** **Date**