



Stonewall
eye care

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing STONEWALL EYE CARE for your vision needs. We are committed to providing you with the highest quality of vision care. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- > The patient (or patient's guardian, if a minor) is ultimately responsible for the payment of provided care and treatment.
- > We will bill your medical insurance, or third party vision program benefit for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- > Patients are responsible for payment of co-pay, coinsurance, deductibles, and all other procedure or treatment not covered by their insurance plan.
- > Co-pays are due at time of service.
- > Medicare does not consider the refraction as a covered benefit. The refraction charge is \$25 and must be paid by the patient. The refraction is the part of the exam in which the doctor determines your need for prescription glasses using numerous optical lenses.
- > Patient may incur, and are responsible for payment of additional charges, if applicable. These charges may include: Charge for return checks- \$25.00

By my signature below, I hereby authorize assignment of financial benefits directly to Stonewall Eye Care and any associated healthcare entities for service rendered as allowable under the standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Patient Name _____
Patient/Guardian Signature _____
Date _____