SEE THE BEST
SLADE & BAKER
VISION CENTER

Patient Financial Responsibility Agreement

The doctors and staff of Slade & Baker Vision Center appreciate the confidence you have shown in choosing them to provide for your medical needs. We are committed to providing you with the highest quality healthcare. Please 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 responsible for the payment for his/her treatment and care.

•Patients are responsible for the payment of copays, coinsurance, deductibles and all other procedures or treatment ***not covered by their insurance plan***. **Payment is due at the time of the service.** We accept cash, checks, money orders, Visa and MasterCard.

•It is the policy of Slade & Baker Vision to collect copays/deductibles/allowables regardless if the patient has a Health Savings Account or Health Reimbursement Account.

•Patients may incur, and are responsible for the payment of the following additional charges:

A $40 fee for all returned checks

Insurance

The following are the patient's responsibility:

1. Pre-Authorization: It is the patient's responsibility to know when authorization/referrals are required for services rendered. The patient must contact their Primary Care Physician for any referrals and also contact their insurance company for Pre-Authorization. We will be happy to assist if your insurance has any requests.

2. Patients must bring their insurance card and drivers license to each visit.
3. If patient fails to provide their insurance information before the date of service this may result in delayed verification of benefits. If so, the patient may be responsible for the full cost of service at the time of service.
4. Determine if doctor(s) are in-network providers prior to first visit.
5. Pay for any allowed amounts not covered by insurance
6. If you do not have insurance benefits, please contact the Billing Department to set up payment arrangements.

I have read, understand and agree to the provisions of this Patient Financial Responsibility Form. In the event of nonpayment or default, I am responsible for all costs and reasonable collection and/or attorney fees.

X _____

Signature of Patient/Responsible Party Print Name Date