David Martin, OD

Alia Santoyo-Johnson, OD, FCSO

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing the Family Vision Development Center as your eye care provider. We are committed to providing you and your family with the highest quality healthcare. We ask that you read and sign this for to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- You are responsible for the payment of your treatment and care.
- If the patient is a minor, then as the patient's guardian you are ultimately responsible for payment of the minor's treatment and care, even if you are not the carrier of your child's insurance policy.
- If you have insurance, we will bill your insurance for you. However, for every visit, you are required to provide correct and updated information regarding insurance.
- You are responsible for payment of:
  - Co-payments
  - Co-insurance
  - Deductibles
  - All other procedures and treatments not covered by their insurance plan.
- Co-payments are due at the time of service.
- Co-insurance, deductibles and non-covered items are due within 30 days from receipt of billing.
- If you do not have insurance, you are responsible for payment of your treatment and care.
- You may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
  - Late fees for past due accounts
  - Charges for returned checks

By my signature below, I hereby acknowledge that I understand that I am responsible for full payment (less any adjustments the Family Vision Development Center is contractually required to make) within 30 days of receipt of my statement. I understand that I am financially responsible for all charges not covered by my insurance.

I have read, understand, and agree to the provisions of the Patient Financial Responsibility Form.

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Name of patient (please print) (Date of Birth)

____ _______________________

Signature of patient or guardian Date

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