Patient Financial Policy

Patient: _____ **Date:** _____

REFERRAL:

If your insurance plan requires a referral or pre-authorization, please contact your primary care physician or insurance and request that a referral be sent to our office. *Failure to obtain a referral will require you to pay for the visit at the time of services*. Being seen without a referral or pre-authorization can result in reduced benefits or no payment by your insurance. If a referral is obtained after you visit, we will be happy to submit to your insurance and then reimburse you what the insurance company has paid. If you are uncertain whether your insurance requires a referral, please contact your insurance carrier.

PAYMENT:

Payment for your care is due at the time services are provided unless we have a contract with your health insurance plan. **Your co-pay and any deductible due are payable at the time of service.**

INSURANCE:

We require your current insurance identification card information. It is your responsibility to ensure the accuracy of information. We will file a claim for your services if Jeffries Eye Associates has a contract with your health insurance plan. However, if your insurance company fails to pay for your services, you may be responsible for any accrued charges. Any co-payment is due at the time services are rendered. If Jeffries Eye Associates does not have a contract with your insurance, payment is due in full the day of your visit..

INSURANCE AUTHORIZATION, ASSIGNMENT OF BENEFITS & CONSENT FOR EXAMINATION:

I hereby authorize Jeffries Eye Associates to give my insurance company, my attorney or my physician any and all information they may require concerning my case. I hereby assign to the clinic all payments for medical services, should it be desired to take such assignment. I understand that I am responsible for all charges regardless of insurance coverage. I further authorize the staff of Jeffries Eye Associates to examine my eyes and perform any services normally associated with an eye examination.

X _____
SIGNATURE OF PATIENT (Guardian or Parent Signature, if minor)

Jeffries Eye Associates
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