

Patient Responsibility Form

Person Name

I understand and agree that I am financially responsible for all charges and all services rendered. This includes any medical service visit, routine examination, refraction, testing, contact lens services and any other screening ordered by the physician.

I understand, and agree, that it is my responsibility to know my insurance policy's: deductible, coinsurance, copayment, prior authorization requirements, usual & customary payment limit, and also any out of network restriction's. The aforementioned are legal obligations per your insurance contract and payment in full is required. I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any balance left unpaid by my insurance.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and it is also my responsibility to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full. If I am a Medicare patient, I understand that I need to provide the office both my Medicare card and my supplement or secondary insurance card. If the office does not have the proper information for my secondary insurance, I will be billed the percentage Medicare does not cover.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and or as required by law. I have the right to revoke this consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior consent. LLCEA/PS provides this form to comply with the Health Insurance Portability and Accountability act of 1196 (HIPPA).

Thank you

Koziol-Thoms Boundaoui Eye Associates

Print Name

Signature

Date