****Financial Policies/Responsibility****

*Many of the services provided in this office are covered and paid for by your insurance company. Unfortunately, not all services are paid by insurance. We do our best to have your benefits ready in advance and to charge you as accurately as possible. Insurance companies sometime misquote benefits. Therefore, we cannot guarantee that your visit and services furnished will be paid in accordance to the quote we receive. Final determination of payment is not made until the claim is reviewed by the insurance company. In cases where the service has not been paid, you will be responsible for the charge. Before we bill you, we will make sure that all of the information provided to the insurance company is accurate and clearly describes the service you received.

*Federal law addressing all insurance companies require that we submit claims to the insurance company accurately, reporting the exact services performed and the exact reason for performing them. Our practice is committed to these laws and will submit claims to all insurance companies in this manner. We are not allowed to change this information so an insurance company will pay the claim. Any professional fees not covered by you insurance will need to be paid in full at the time of service.

By signing below, you agree to pay for all services rendered to you, to the extent that you are legally responsible for. Understand you are responsible for all insurance co-pays and deductibles or coinsurances. If however, we are not on your insurance plan, we will require full payment at the time of service for all medical services and products provided, but will provide you with an itemized receipt to submit toy you insurance for potential reimbursement. Claims not paid due to errant or undisclosed insurance information provided by the patient will be the responsibility of the patient.

*I understand that payment collected today is based on a quote of benefits provided by my insurance carrier and therefore is not a guarantee for benefits. Final determination can only be made once the claim is reviewed by my insurance provider.

I have read and understand the financial policy and I do accept financial responsibility.

_____ _____

(Signature of responsible party) (Date)

***Assignment of Insurance Benefits****

I authorize payment of my medical/vision benefits to Ahlquist Eye Care Professionals. I authorize Ahlquist Eye Care Professionals to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

_____ _____

(Signature of Responsible Party) (Date)

***Consent to treat a minor****

By law, any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian, If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

_____ _____

(Signature of Responsible Party) (Date)

For those occasions when you may not be with your child, please list those individuals who may give us consent to see your child:

_____ _____

Name Relationship to patient