

# Dimond Vision Clinic

## Statement of Patient Financial Responsibility & Acknowledge of Receipt

Dimond Vision Clinic appreciates the confidence you have shown in choosing us to provide for your eye care needs. The services and/or goods you have elected to receive, implies a financial responsibility on your part.

As a courtesy, we will bill your primary insurance carrier on your behalf. However, you are ultimately responsible for all fees. I understand that billing of any secondary insurance is my responsibility.

I understand that I am responsible for co-payments, deductibles and out of pocket expenses as dictated by my insurance at the time the service is rendered.

**Initial** \_\_\_\_\_

I understand that benefits quoted to Dimond Vision Clinic by my insurance company is not a guarantee of payment by my insurance company and that final determination can only be made by my insurance company when the claim is processed. It is ultimately the patient's responsibility to know your coverage and benefits.

If payment is denied, I understand that I am responsible for payment in full.

**Initial** \_\_\_\_\_

I understand that it is my responsibility to provide Dimond Vision Clinic with the correct primary insurance information at the time services are rendered. If payment from my insurance company is not received by Dimond Vision Clinic within 90 days of date of service, the balance then becomes my responsibility.

**Initial** \_\_\_\_\_

If payment is received by Dimond Vision Clinic for fees not billed by Dimond Vision Clinic those funds will be returned to the issuing insurance company. If payment is received by Dimond Vision Clinic that results in overpayment of fees due, the patient will be reimbursed for any out of pocket monies the patient incurred. Any amounts over what was collected from the patient will be returned to the issuing insurance company.

**Initial** \_\_\_\_\_

I authorize Dimond Vision Clinic to furnish information concerning my care to my insurance company.

**Initial** \_\_\_\_\_

I authorize my insurance company to make payment directly to Dimond Vision Clinic.

I fully understand that any account 90 days old is subject to collection fees. In the event that outside collection and/or legal costs are incurred by Dimond Vision Clinic in an effort to obtain payment, I am responsible for those costs.

**Initial** \_\_\_\_\_

I acknowledge that I have received the **Notice of Privacy Practices** and I have also read the above policy regarding my financial responsibility to Dimond Vision Clinic for providing services or goods to me. I certify that the information that I have provided to Dimond Vision Clinic is true and accurate. I understand that that I am ultimately responsible for payment in full for all services and/or goods associated with my account.

**Date** \_\_\_\_\_ **Name of Patient** \_\_\_\_\_

**Signature of Patient or Parent/Guardian if under 18** \_\_\_\_\_