CHICOPEE
—EYECARE—

113 Center Street ● Chicopee, Massachusetts 01013 ● (413) 592-7777

PATIENT FINANCIAL AGREEMENT

Patient Responsibilities

. You are responsible to provide us with accurate billing information for each family member at the time of service.
. If your insurance company requires you to choose a primary care provider (PCP), it is your responsibility prior to your visit to ensure that you have authorization for your visit with us.
. Our billing staff is available to provide you with assistance, but cannot resolve disputes between you and your insurance company.

Copayments

. Your insurance company requires you to pay your copay at the time of each visit.
. Your copay may be paid with cash, check, credit card, or debit card.
. If your check is returned, a $25.00 returned check fee will be assessed.
. If you do not have insurance coverage, you will be expected to pay at the time of your visit.

Deductibles

. It is your responsibility to understand any deductibles that may apply to you under your insurance policy.
. Our billing department will send you a statement of the amount your insurance company has determined is applied to your deductible and is owed by you.

Insurance Information

. It is your responsibility to ensure that we have accurate insurance information. Presenting an invalid or inactive insurance card will result in full payment by you.
. Medical insurance does not always cover the entire cost of your medical care. If we believe a service we offer is not covered by your insurance coverage, we will tell you.
. In some instances, however, we do not learn that a service is not covered until after we submit a bill. You are responsible for payment if your insurance company refuses to pay for a service.

Home Address and Telephone Numbers

. You will be asked to complete a patient registration form that asks for important information about you. Please complete this form to the best of your knowledge and keep us informed of any changes on subsequent visits.
. It is important that we have accurate information on the guarantor. This is the person who is financially responsible for your bills.

Assignment and Release

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Recent changes in insurance regulations shorten the time frame for claim submissions. I agree to pay any out of pocket expenses in full to Chicopee Eyecare within thirty days from today's date for uncovered or denied services by my presented insurance coverage.

Signature_____Date_____