ARIZONA EYE CONSULTANTS

PATIENT FINANCIAL AGREEMENT

Arizona Eye Consultants is committed to serving our patients with professionalism and caring. We ask the same from you. This includes:

- Arriving on time for your appointment and calling to cancel an appointment if you are unable to attend your scheduled appointment.
- Financial responsibility, presenting your current identification and insurance cards, and providing accurate and complete information concerning your primary and\or secondary and tertiary insurance medical benefits as well as any referral documents from other providers.
- All copayments, coinsurance, deductibles and any balances from prior visits are due at the time of service with cash, check or credit card. Payment arrangements, if able, can be made by our Billing Team.
- Please call your insurance company if you have any questions regarding your co-pay, coinsurance or deductibles on test(s) that Arizona Eye Consultants may have ordered outside of our facility such as radiology, laboratory, pathology, etc.

Arizona Eye Consultants will not assume financial responsibility for services rendered that may require a prior authorization or prior approval from the patient's insurance company or referral from Primary Care Physician.

If having surgery:

- Please note that surgical fees associated with a hospital or outpatient surgical centers are separately billed services by a separate entity for services outside of our clinic.
- It is your responsibility to know which facility you are required to use per your insurance. If you aren't sure, please talk to your insurance member services or one of our staff prior to scheduling.

Patient Acknowledgement

I agree that I am fully informed and aware of my financial agreement with Arizona Eye Consultants. I also have read and understand the following:

1. A $25.00 fee will be charged for any returned checks.
2. I am financially responsible for any non-covered and/or denied charges incurred on my behalf and that it is my responsibility to know my insurance coverage.
3. I will be responsible for any missed appointments or any cancelled appointment in which a 24-hour notice was not given. There will be a fee of $25.00 for any missed office visits and $100.00 for any missed scheduled procedures **(Surgical Procedures must be canceled within 1 week)**
4. If the reason for my visit is related to a work injury, I agree to give Arizona Eye Consultants the case number, the workmen's compensation name, address or other contact information at the time of my appointment so that Arizona Eye Consultants can bill workman's compensation for my visit. If I do not provide this information at the time of visit, I agree to pay all charges for my visit(s).
5. There will be a 30% fee on top of all balances turned over to an outside collection agency. My account must be paid in full prior to scheduling any further appointments.
6. A copy of this agreement may be used in place of the original.

I also acknowledge the following:

- I request that Arizona Eye Consultants file claims on my behalf to the Insurance Company(ies) listed on my file for any services furnished to me by a Physician or Employee of Arizona Eye Consultants. I authorize Arizona Eye Consultants to release to the insurance company(ies) and its agents any information needed to determine those benefits payable for related services.
- I am personally responsible for any portion of my bill not paid by my Insurance to include copays, coinsurance, deductibles or any other reason for payment denial stated by my insurance. I understand that it is my responsibility to resolve disputes over payment with my insurance company.
- Failure to comply with above said agreements will result in any unpaid financial responsibility being turned over to a collection agency. I agree that it will
- ***For Medicare Patients***: If Arizona Eye Consultants believes that Medicare will not pay for all or part of a requested service, I will be asked to sign an Advanced Beneficiary Notice (ABN) signifying that I understand Medicare may not pay and that I am personally responsible for the charges. If Medicare pays in part, I agree to be responsible for my portion of the deductible and coinsurance not covered by Medicare.

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Full Name of Patient

_____ _____

Signature of Patient or Legal Representative Date