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**PATIENT FINANCIAL RESPONSIBILITY DISCLOSURE STATEMENT**

Your signature below forms a binding agreement between Cincinnati Eyecare Team (CET- the provider of medical services) and the Patient who is receiving medical services or the Responsible Party for eligible dependents. The Responsible Party is the individual who is financially responsible for payment of medical bills.

All charges for services rendered are due and payable at the time of service.

**MEDICAL INSURANCE.** We have contacts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.

The person signing on behalf of the patient as the Responsible Party must:

- Inform CET of the current address, phone number and birth date of the patient and the responsible party.
- Present all current insurance cards prior to each office visit.
- Pay any required co pay at the time of the visit.
- Pay any additional amount owing within 30 days of receiving a statement from our office. (When CET receives an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you)

**Returned Check Policy**

If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to \$35.00 Service Charge once notice is received of returned check. CET will send out a letter to notify the Responsible Party of the returned check. If a response is not made within 10 days from the letter date by the Patient or the Responsible Party, the account may be turned over to our collection agency, or the local law enforcement agency.

**Non-Payment on Account**

Should collection proceedings or other legal action become necessary to collect an overdue account, the Patient or the patient's Responsible Party, understands that CET has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services or as the Responsible Party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name (Please Print) \_\_\_\_\_

Responsible Party Name (Please Print) \_\_\_\_\_

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_