VISION SOURCE®

Financial Assignment and Agreement

Please remember that insurance is considered a method of reimbursing the patient for a fee paid to the doctor and is not a substitute for payments. Some companies pay fixed allowances for certain procedures, and others pay a percentage of that charge. **IT IS YOUR RESPONSIBILTY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURNACE OR ANY BALANCE NOT PAID FOR BY YOUR INSURANCE COMPANY.**

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to be released to the Health Care Administration, its agents or any other insurance carrier I may have. Also, any information needed to determine these benefits or the benefits payable for related services.

Refraction Policy

Refraction is the process of determining the eye's refractive error, or need for corrective spectacle and/or contact lenses. It is an essential part of an eye examination, but is NOT a covered service by Medicare or most insurance companies. Vision Source of Texarkana fee for refraction is $23.00 and this fee is collected in addition to the patients copay. **REFRACTION FEE AND COPAYS ARE DUE AT TIME OF SERVICE.**

Contact Lens Exam

A contact Lens patient requires additional testing and monitoring over and above what is done during a routine eye examination. In order to prescribe or renew your prescription, your doctor performs additional procedures that that are apart from a regular eye examination. Depending on the level of examination there is a fee associated with a contact lens examination that is not covered by Medicare and most insurance companies. **THIS FEE AND ANY COPAYS ARE DUE AT TIME OF SERVICE.**

Return Check Policy

I understand that if my check is returned unpaid, I will be charged and responsible for the value of the check and a $25.00 return check fee.

Acknowledgement

I have read the above information and understand and accept full financial responsibility for any additional costs or copays that are not covered by Medicare or my insurance company.

Patient Signature:_____Date:_____