CAPE FEAR EYE
associates, p.a.

PATIENT FINANCIAL AGREEMENT

PLEASE READ THOROUGHLY AND SIGN BELOW

In consideration of receiving services from Cape Fear Eye Associates, You agree:

1. All services are provided to you with the understanding that you are responsible for the cost regardless of your insurance coverage. If you would like to know the cost of services, please inquire prior to treatment. Please be aware that not all services are a covered benefit with different insurance companies. You are responsible for knowing what services are or are not covered. Know Your Benefits.

2. Upon Check-in, we will collect your deductible, co-pay, and payment for any uncovered service as well as the patient's portion as determined by the insurance. We accept cash, check, and credit cards.

3. Your insurance policy is a contract between you and your insurance company. We are NOT a party to that contract. If there are any changes made to your insurance prior to services you are responsible for informing our office of these changes.

4. You are responsible of knowing if a referral is required. Make sure you know what physicians are in network with your plan, what facilities are covered and what ancillary services you must use. (such as laboratory, hospitals, etc.) If we can be of assistance, please let us know.

5. Any unpaid charges over 90 days old will be turned over to an outside collection agency. You are responsible for any collection fees, legal fees, or court costs incurred in the collection process. This agency will report your failure to the THRE national credit reporting agencies.

6. There will be a minimum charge of $75.00 if the office is not notified 24 hours prior to the appointment date, so please contact the office during hours of 8:00am to 5:00pm if you need to cancel.

7. Returned checks are subject to a $30.00 return check fee.

8. If forms are to be filled-out by your provider, there is a $25 fee for completion of these forms. Any medical records that are being requested to pick up is a fee starting $0.75 per page 1-25, $0.50 per page 26-100, $0.25 per page over 100.

We understand that temporary financial problems may affect timely payment. We encourage you to communicate any such problems so that we can assist you in the management of your account.

_____ _____

Patient/Guardian Signature Date

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