Waters Family Eyecare Financial Responsibility Agreement

I authorize Waters Family Eyecare to bill my insurance company for services rendered and/or materials purchased. I understand that only covered services will be billed. All co-pays are due at the time of exam. If the service is not covered, then that balance is my responsibility and is due when services are rendered. If the insurance company does not pay the claim within 60 days and/or if they only pay a portion on the claim, I understand that I am responsible for paying the remaining balance.

If the outstanding balance is not paid within 90 days, then there will be a service charge of 25% added to the remaining balance and the account will be forwarded to our collection agency. Returned checks will be charged a service fee of $50.00.

We require a minimum 50% down payment before any materials order is placed and all balances must be paid in full before materials or prescriptions can be released. We accept Care Credit and all major credit cards for your convenience.

If we are not billing your insurance company, then payment for all services including: exams and/or contact lens evaluations are due at the time services are rendered.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient