NOTICE OF PATIENT RESPONSIBILITY POLICY

* Please Initial All Spaces Below: This is an acknowledgement of our policy even if not applicable to your situation.

_____**SERVICES PROVIDED WITHOUT REFERRAL AUTHORIZATION:** As a member of a vision care program, I acknowledge for today's visit that I will assume full financial responsibility for services rendered to me, **if** my vision insurance carrier denies or does not cover my claim for these services.

_____**MEDICAL NECESSITY:** If my insurance determines that a medical service and/or material are not covered, I acknowledge that I have been notified and will assume full responsibility for the services and/or materials.

_____**CO PAYS:** I understand that I am responsible to pay all co-payments at the time of service, prior to leaving. Co-pays can not be waived at any time by the provider of service or Kenai Vision Center.

_____**DEDUCTIBLES:** If my insurance determines that I have not met my deductible, I understand that I will be fully responsible for payment in a timely manner, no more than 30 days after I have been notified by my insurance and/or provider. Yearly deductibles **can not** be waived at any time by the provider of service or Kenai Vision Center.

_____**AGREEMENT TO PAY:** I have been notified in the above information by this provider that I am fully responsible for all services and/or material if my insurance does not cover or denies payment for a service or materials or both. I understand and agree to be financially responsible.

_____ **COLLECTIONS:** We will send you to collections if we do not receive payment in full within 90 days of service.

_____ _____

DATE **PRINT PATIENT NAME**

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PATIENT OR GUARDIAN SIGNATURE

We will file insurance as a courtesy to you, but we will **NOT** contest with your insurance company