Patient Financial Responsibility Agreement

The doctors and staff of East Texas Vision Center appreciate the confidence you have shown in choosing them to provide for your eyewear needs. We are committed to providing you with the highest quality vision. Please read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is responsible for the payment for his/her treatment and care.
- Payment is due at the time of the service. We accept cash, checks, debit and credit cards.
- Patients may incur, and are responsible for the payment of the following additional charges:
  - A $25 fee for all returned checks.
  - A 20% restocking fee for any contact lenses returned to the manufacturer.
  - A 20% remake fee for any Rx changes from an outisde Dr.

Insurance

The following are the patient's responsibility:

- Patients must bring their insurance card to each visit
- Notify our office of any changes to insurance
- Patients are responsible for the payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Pay for any allowed amounts not covered by insurance
- If we are filing for payment to our office and the insurance company remits payment to you by mistake, you are responsible for sending the check and any documentation sent with the check to our office.

I have read, understand and agree to the provisions of this Patient Financial Responsibility Form. In the event of nonpayment or default, I am responsible for all costs. East Texas Vision Center reserves the right to change or amend this statement at any time and at its discretion.

_____	_____	_____
Signature of Patient/Guardian	Printed Name of Patient	Date