Patient Financial Responsibility

- I authorize the release of any medical or other information necessary to process claims on my behalf.
- I request payment of Medicare, government or other benefits to be paid directly to Eye Appeal Optical or its providers for services rendered.
- I understand that I am financially responsible for all materials and services rendered. If a claim has been submitted on my behalf, I may receive a bill for services that were not reimbursed by my insurance and could include, but are not limited to non-covered services, deductibles or co-insurance not paid at the time of the visit.
- I agree that if this account is not paid when due, and the doctor/Eye Appeal Optical should retain an attorney or collection agency for collection, I agree to pay all costs of collection including reasonable interest, reasonable attorney's fees (whether suit is filed or not) and/or collection agency fees (including feesbased on a percentage basis of the amount owed to 33 1/3 percent)
- I understand Eye Appeal Optical is not responsible for submitting claims or accepting contracted fees if I have not provided the necessary information needed to process a claim on my behalf before services have been rendered.

Signature _____

Print Name _____

Date _____

Relationship to patient _____

1097 Route 55, Suite4, LaGrangeville , NY 12540