Kaye Eyecare of Huntley, Ltd.
Statement of Patient Financial Responsibility

Patient Name:_____DOB:_____

Kaye Eyecare of Huntley, Ltd. appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. We will bill in-network medical insurance you provide to us. However, you are ultimately responsible for payment of your bill. In the event your exam necessitates a higher level of medical service, and you have declined to provide us with your insurance information, you will be billed our usual and customary services fees at the time of your appointment. I understand it is my responsibility to know and understand my insurance benefits and networks. I further understand it is my responsibility to inform Kaye Eyecare of my insurance and any changes to my insurance.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. Co-Payments are required for EACH VISIT and we expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your carrier denies any part of your claim, or if you and your physician elects to continue past your approved period, you will be responsible for your balance in full.

If you make a payment that results in a surplus on your account, you authorize Kaye Eyecare to apply the overpayment to any other account for which you are financially responsible, including your account, a member of your family's or dependent's account, or on any account for which you are a financially responsible party, and any remaining balance will be returned to the payor.

If a payment is made by check and it is returned or declined for any reason, your account will be charged a surcharge of $30.00.

I have read the above policy regarding my financial responsibility to Kaye Eyecare of Huntley, Ltd. for providing services to me or the above name patient. I certify that the information I provided is, to the best of my knowledge, true and accurate. I authorize my insurers to pay the full and entire amount of any benefits incurred by me or the above named patient directly to Kaye Eyecare of Huntley, Ltd. If applicable, I will remit, in full, any amount remaining after payment has been made by my insurance carrier to Kaye Eyecare. If any payment is made directly to me for services billed by Kaye Eyecare, I agree to promptly submit same to Kaye Eyecare until my account is paid in full.

Patient/Guardian Signature:_____Date:_____

Cancellation/No Show Policy

We understand there may be times when you miss an appointment due to emergencies, illness or obligations to work or family. However, we ask that you call a minimum of 24 hours prior to your appointment time to cancel or change your appointment. **Kaye Eyecare will charge you $25.00 for all Missed Appointments.** A Missed Appointment results when you do not attend a scheduled appointment, or you did not cancel a scheduled appointment at least 24 hours in advance. A failure to present at the time of a scheduled appointment will be recorded in your medical records as a "no-show" and the Missed Appointment fee will be charged. The Missed Appointment fee is not billable to your insurance and must be paid by you directly. Any exceptions to this policy will be reviewed on a case by case basis and will take into consideration emergency or unanticipated situations.

By signing below, you are acknowledging that you have read, understood and agree to these conditions.

Patient/Guardian Signature:_____Date:_____

We would be happy to provide a copy of this signed form for your records upon request.