Santa Clara Ophthalmology
Financial Assignment and Agreement

To help achieve our goal of providing the best medical care possible, we ask for your understanding and cooperation regarding the following payment/insurance policies:

Payments
We ask that payments, including any applicable deductible or copayment, be made at the time of service unless other arrangements have been made in advance. For your convenience, we accept cash, check, money orders, debit cards, and most credit cards.

Patients with HMO or POS Insurance
If you are a member of an HMO or POS plan, you need to have a valid referral from your primary medical doctor for each office visit and surgical procedure. Prior to your visit, please call in advance to ensure that all necessary forms and authorizations are in place. Without a valid referral, financial responsibility will lie upon the patient, and full payment will be due at the time of service.

Refraction Charge
For patients whose insurance does not cover refractions, we ask that payments be made at the time the new prescription for eyeglasses is dispensed.

Late Payments
It is our policy to render periodic statements for services on a monthly basis. We reserve the right, at our option, to charge interest on outstanding balances beyond 60 days at a rate of 5% per month.

Returned Checks
Returned checks will incur an additional $25 fee.

I hereby authorize Santa Clara Ophthalmology Incorporated, its Doctors, and/or agents to apply for reimbursement benefits on my behalf for services rendered to me. I understand that payment from my insurance carrier will be made directly to Santa Clara Ophthalmology Incorporated. I further authorize the release of any information necessary to process any claim with my insurance carrier. I understand that I am financial responsible for all charges, including those not covered by my health insurance. I further understand that I will be responsible to pay for any service denied by my insurance company.

I have read and understand the payment policy and agree to abide by its guidelines.

_____ _____

Patient's Signature Date