Financial Responsibility

To our patients with Medical and/or Vision benefits:

We will be happy to file your insurance claim forms or take assignment on your medical/vision benefits as designated by the insurance plan(s) of which you state you are a member. We will do all we can to help you receive maximum benefits. However, in the event that the plan sponsor determines that you are not eligible for coverage at the time of service, or makes a determination that you are eligible for a reduced level of coverage, by signing this statement you hereby agree to be financially responsible for any and all charges incurred by you and not paid by the plan sponsor.

Please note that **you are ultimately responsible** for knowing what your insurance will cover. If you have any questions about your coverage, please call the number on the back of your insurance card. We do our best to get this information, but as every plan is different, we are not able to call all of them prior to your appointment.

* if you fail to pay your bill, you will be responsible for an additional 30% fee if you are sent to collections.

No Show Policy:

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, please be respectful of our time. A **$25 fee** may be assessed for missing a scheduled appointment without contacting us to cancel or reschedule at least **24 hours** in advance.

Print Name _____

Sign Name _____ Date_____

MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Rhiannon L. Maggiore, O.D., P.A. for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determination these benefits or the benefits payable for related services.

_____ _____

Date Signature of Patient (or Responsible Party)