PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Olson Eye Care for your vision needs. We are committed to providing you with the highest quality of vision care. We ask that you 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 ultimately responsible for the payment of provided care and treatment.
- We will bill your medical insurance, or 3rd party vision program benefit for you. (Example: VSP, Eyemed, Avesis). However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of co-pays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan.
- Co-pays are due at time of service.
- Medicare does not consider the refraction as a covered benefit. The refraction charge is $50.00 and must be paid by the patient. The Refraction is the part of the exam in which the doctor determines your need for prescription glasses using numerous optical lenses.
- Coinsurance, deductibles, and non-covered items are due 30 days from receipt of billing.
- Patient may incur, and are responsible for payment of additional charges, if applicable. These charges may include: Charge for return checks - $40.00

By my signature below, I hereby authorize assignment of financial benefits directly to Olson Eye Care and any associated healthcare entities for services rendered as allowable under the standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Patient Name: ______________________________

Patient/Guardian Signature: ______________________________

Date: ____________________

Email Form to Olson Eye Care

Print Form and Bring to Office