**ATTLEBORO OPHTHALMOLOGICAL ASSOC., INC.**

**Acknowledgment of PATIENT FINANCIAL POLICY**

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Patient /Printed Name Patient Birth Date

***I have received, read, understood, and hereby agree to the Attleboro Ophthalmological Assoc., Inc. Patient Financial Policy.***

*I understand that charges not covered by my insurance plan, as well as applicable copayments and deductibles, are my responsibility.*

*I understand that repeated missed appointments may result in my inability to make future appointments.*

*I understand that it is my responsibility to be familiar with my insurance plan and what benefits it provides. This includes what copayment and deductible amounts are and when I need to obtain referrals and authorizations prior to treatment.*

*I acknowledge that if I do not have a valid referral from my Primary Care Physician, for this specialty care, I will be responsible for payment of these services if payment is denied by my health insurance company.*

*I authorize my insurance plan to assign and/or pay benefits directly to Attleboro Ophthalmological Associates, Inc.*

*I authorize Attleboro Ophthalmological Associates, Inc. to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.*

*I request that payment of authorized Medicare benefits be made on my behalf to Attleboro Ophthalmological Associates, Inc. for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the Medigap insurer any information needed to determine benefits payable for services from this provider. This authorization applies to all occasions of service and is in effect until I choose to revoke it.*

*I understand that my bills need to be paid to Attleboro Ophthalmological Assoc., Inc. within 60 days.*

*I understand that if my account is past due after 60 days that my account may be referred to a collection agency and credit reporting bureau if I have not set up a scheduled payment plan.*

*I am responsible for all costs incurred/associated with the collection of any amount past due to Attleboro Ophthalmological Assoc., Inc.*

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**Signature of Patient or Legal Guardian**   **Date**

Revised 3/29/19