Justin Verrone, O.D.
Benjamin Peters, O.D
Stephanie Lovett, O.D.
Shruti Pandya, O.D.
Kenneth Lindahl, M.D.

EYESITE

Patient Name: _____ **Today's Date:** ___/___/_____
Last First

Date of Birth: ___/___/_____

Authorization for Release of Medical Information
to the Payer and Assignment of Benefits to the Physician

I hereby authorize release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to Dr. Justin Verrone, and/or Dr. Benjamin Peters. I understand that I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is valid as the original.

Signature of patient or guardian: _____ **Date:** ___/___/_____

Office Financial Policy:

- All payments for services and procedures and materials are expected on the day of appointment.
- If co-pay is not made at time of service, there will be a fee of $10 added onto the balance due.
- For your convenience, our office accepts payment in the form of Cash, Check, Visa, MasterCard, Discover.
- There will be a fee of $30 on all returned checks.
- If payment on a delinquent account has not been made within a three month period, the account will go into collections.
- In the event that your account is referred to a collection agency, you will be responsible for all fees incurred for the collection of your bill; this includes attorney fees, court costs, and collection agency fees.

As a courtesy, we confirm your insurance benefits the day before you come to the office. All insurances do not guarantee any information provided to use over the phone or by the internet. If is the patient's responsibility to be familiar with their insurance policy, covered and non-covered benefits, as well as frequency and limitations of their coverage. Insurance companies select certain services that they will cover, as a result, not all procedures are covered by every insurance. The patient/guardian is responsible for cost of eye care and/or eyewear not covered by insurance contract.

I have read and understand the above financial policy.

Signature of patient or guardian: _____ **Date:** ___/___/_____

Direct all questions regarding bills, payments, or insurance coverage to our billing department, or your insurance carrier