APPLE HILL EYE CENTER
PATIENT FINANCIAL RESPONSIBILITY
DISCLOSURE & AGREEMENT

The purpose of this disclosure and agreement is to make you aware that you are financially responsible for your bill for medical and optical services rendered to you by Apple Hill Eye Center.

Our office does not wish to cause undue hardship for any of our patients, and quality care is our primary goal. Should a financial hardship exist, our Billing Department will discuss alternative payment methods on an individual basis.

Your insurance policy is a contract between you and your insurance company. We do not accept the responsibility of negotiating claim disputes for you. You are responsible for payment of all charges, regardless of the status of any insurance claim. **Co-payments and deductibles, as well as charges for refraction and other non-covered services will be collected at the time of the office visit.** Rejection or reduction of your claim by your insurance company does not relieve you of your financial responsibility. Please note, effective April 1, 2009, there will be a $5 monthly rebilling fee for all balances over 60 days from service date.

If your account is assigned to a licensed collection agency, you agree to pay the collection agency fee which is currently a net of 40% in addition to the outstanding account balance. Should it be necessary to assign your account balance to a District Magistrate or attorney for legal action, you shall pay subsequent legal fees. Returned checks are subject to a $25 fee.

Our no-show policy is as follows: a 24-hour notice is required. After the first no-show appointment you will receive a phone call to remind you of the missed appointment and to reschedule your appt. After the second no-show you may be charged $35 (or $100 for Dr. Michael Altman) for the time slot we were not able to fill when you were a no-show.

We want your experience with Apple Hill Eye Center to be a positive one, and our office will be happy to help you with your medical and financial concerns.

I do hereby guarantee unto Apple Hill Eye Center, the prompt payment of all bills incurred by me or my dependent patient and any costs as indicated above.

Patient Name (PRINT PLEASE):_____

Signature of responsible party:_____ **DATE**:_____