

SURE SIGHT EYE CARE, LLC

Dr. David Wayland

Dr. Chad Ferdon

Dr. Brian G. Shipley

Financial Responsibility Statement

1. To our patients using their Vision or Medical Insurance Benefits:

[] I decline the option of using my insurance benefits for the services rendered today. I agree to pay for all fees at the time of service. My method of payment will be: (Please Circle One)

Cash

Check

Credit Card

Debit Card

2. To our patients using their Medical Insurance Benefits:

We will be happy to help you file your insurance claim forms or take assignment on your vision benefits as designated by the third party plan of which you state you are a member of (if we are allowed). This service will be provided without additional charge to you. We will do all that we can to help you receive maximum benefits.

However, in the event that the Plan Sponsor determines that:

1. You are not eligible at the time of the claim;
2. You are eligible at a reduced level of coverage;
3. Or fails to remit a payment on your behalf within 60 days of service;

[] I hereby agree to be financially responsible for any and all of the charges incurred by me and not paid by my insurance plan. For reimbursement, I authorize my insurance plan to pay the provider directly. If this is not allowed by my policy, then I authorize the insurance plan to send the check made out to me at the address marked above.

3. I HAVE READ AND UNDERSTAND THE FINANCIAL RESPONSIBILITY POLICY.

Insured Signature _____ Date _____

Please provide the following information necessary to process you insurance claim:

Insurance Information

Insured/ Primary Information

Insurance Company Name: _____ Name: _____

Insurance Company's Phone No: _____ Date of Birth: _____

Employers Name: _____ Social Security No: _____

Employer's Group/ Plan Number: _____ Member ID No: _____

Patient Information (if different from Insured):

Name: _____

Date of Birth: _____
