Financial Policy Acknowledgment

I understand that regardless of insurance coverage, I will receive a statement for any balance due after appropriate insurance processing and I am financially responsible for all charges including any co-payments, deductibles, non-covered or denied services, fees or any charge not paid by the insurance company.

I have read and understand the Financial Policy for Shillington Eye Associates and agree to the content. I also understand that the policy is subject to change at any time at the discretion of management, formally or informally, either verbally or in writing.

Patient Signature____ Date ________________

Patient Representative Signature_____________________________________ Relationship________________

I acknowledge that I have received a copy of the Shillington Eye Associates, LLC financial policy

Date _______ Patient/Representative Signature________________________________ Relationship________________

Date _______ Patient/Representative Signature________________________________ Relationship________________

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