## *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. *A full copy of the Shillington Eye Associates Financial Policy is available upon request.*

**Delinquent Accounts** - Failure to pay on an existing account balance will result in an additional late fee. If there is no payment made with in 90 days, the account may be sent to collections where you will also be responsible for the collection's fees, attorney fees, court fees and/or interest fees.

Patient Name (Print) ________________________________________ Patient Date of Birth ______________

Patient Representative Name (Print)__________________________________ Date ________________

Patient/Representative Signature ________________________________ Relationship______________

**I acknowledge that I understand and agree to follow the Shillington Eye Associates, LLC financial policy**

Date________ Patient/Representative Signature ______________________________Relationship ______________

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*(Updated 03/2024)*