PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for choosing Fox Eye Care Group (FECG) as your eyecare provider! The services you seek here imply an obligation on your part to ensure payment in full is made for the services you receive. This Patient Financial Responsibility Agreement will assist you in understanding that financial responsibility.

Consent: I consent to treatment and services ordered by my Optometrist at FECG. I understand my eyecare provider may perform medically necessary services, as well as "elective" services, according to current standard of care guidelines. I do have the right to consider or decline services prior to them being performed. My consent to undergo treatment and/or services will be considered a non-verbal agreement to pay for the services provided to me.

Responsibility: I understand that I am ultimately responsible for all payment obligations arising out of my treatment and care and I guarantee payment for these services. I understand am responsible for deductibles, copayments, co-insurance, or any other patient responsibility amounts indicated by my insurance carrier, pursuant to my particular plan. I am also responsible for any services not covered by my insurance.

Payment is due at time of service, and for your convenience, FECG accepts cash, check, and most major credit cards.

I may incur and am responsible for the payment of additional charges at the discretion of FECG. These charges may include, but are not limited to:

- Charge for returned checks
- Charge for missed appointments without 24 hour advance notice
- Charge for copying and distribution of patient medical records
- Charge for extensive forms completion
- Any costs associated with the collection of patient balances, including the use of a collection company and/or attorneys

Insurance Policy: It is my responsibility to know and understand my insurance policy, both the coverage benefits and the policy limitations. I understand that I am personally responsible for payment when: (i) my health plan requires prior authorization/referral by a primary care physician (PCP) before receiving services, and I have not obtained such an authorization or referral; (ii) I receive services in excess of the authorization/referral; (iii) my health plan determines the services I received are not medically necessary and/or not covered by my insurance plan; (iv) my coverage has lapsed/expired at the time services are rendered; (v) I have chosen to utilized my out-of-network benefits; or (vi) I have chosen not to use my health plan coverage for services I receive.

Minor Patients: The parent/guardian presenting with a minor for care is the responsible party for the payment of the minor's account balance regardless of any court order or arrangement to which the parents may have agreed. FECG will not act as administrator to resolve financial agreements.

Authorization to Contact: I authorize FECG, or any collection agency or attorney hired by FECG, to communicate with me by phone, mail, answering machine message, text message, or email. I may be contacted for purposes related to my account, including debt collection, using any information I have provided. I authorize FECG to use this information in any manner consistent with the information I have provided. I expressly understand that this contact may result in charges to me and may include the use of text message, automated dialing machines or other telephone technology, including the use of live, prerecorded or artificial voice messages.

Acknowledgement: I understand I am ultimately responsible for payment of services I receive at Fox Eye Care Group, regardless of my vision/health insurance coverage. I understand that Fox Eye Care Group will not act as administrator to resolve my personal financial agreements regarding my eye care. I have had the opportunity to read this Patient Financial Responsibility Agreement in its entirety and have had the opportunity to ask questions regarding the details of this Agreement. Any questions have been answered to my satisfaction. I consent and agree to the aforementioned policies of Fox Eye Care Group and understand they may be altered without notice.

Signed and agreed to this date: _____

_____	_____
Patient Name (Please Print)	Parent/Guardian Name (Please Print)
_____	_____
Signature	Signature
_____	_____
Date of Birth	Date of Birth