5017 W Highway 290
Austin, TX 78735
www.sunsetvalleyeye.com

SUNSET VALLEY
EYECARE

Ph: (512) 892-2015
Fax: (512) 892-2016
contact@sunsetvalleyeye.com

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Sunset Valley Eyecare and/or its affiliated entities for any charges not covered by health care benefits. It is my responsibility to notify Sunset Valley Eyecare of any changes in my health care coverage, or of any other insurance benefits. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. A quote of benefits by the insurer is not a guarantee of payment, and occasionally benefits are quoted incorrectly by the insurer. I am responsible to know and inform Sunset Valley Eyecare of any other primary insurance benefits which may require you to file claims to the primary insurance only, and failing to do so may result in a claim that may be retroactively denied. I am responsible for the entire bill or balance of the bill as determined by Sunset Valley Eyecare and/or my health care insurer if the submitted claims or any part of them are denied for payment, or retroactively denied. I understand that by signing this form that I am accepting full financial responsibility as explained above for all payment for medical or vision services and/or supplies. Any unpaid balance over 90 days will be sent to collections and a 20% collections fee will be added to the balance.

Patients Initials: _____

Assignment of Benefits:

I hereby authorize and request that the assigned insurance company pay directly to Sunset Valley Eyecare for the amount due in my pending claim for vision or medical treatment or services by reason of such treatment or services. I further assign to Sunset Valley Eyecare all rights afforded to me under ERISA with respect to the services rendered, including the right to bring an action to enforce ERISA and my ERISA rights. I understand that insurance is a private arrangement between myself and the insurance company, and that I am fully responsible for all monies due as a result of the services, products, or treatments provided to me by this office.

Patients Initials: _____

Notice of Privacy Practices:

I acknowledge that I have been given the Sunset Valley Eyecare Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official.

Patients Initials: _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____

Patient (or responsible party) Signature ***Date***