

Woodbridge Eye Care Financial Policy

If you have medical insurance that covers eye care or other vision insurance, we are glad to assist you in obtaining your maximum allowable benefits. You will be responsible for any co-payments, deductibles or fees for non-covered services. Payment for services is due at the time the services are rendered unless other payment arrangements have been made and approved by our staff. We will bill and receive payment directly from your insurance company for covered services.

By signing below I understand that my insurance coverage is a contract between myself and my insurance company. The doctors and staff will make every effort to verify my benefits before my appointment, but no guarantee can be made that the information received is accurate since incorrect information may be provided by my insurance company from time to time. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I understand that it is ultimately my responsibility, as the patient to understand my vision and/or health insurance coverage as well as handle any charges my plan does not cover. I authorize the use of this signature on all insurance submissions.

I have read, understand and agree to the Financial Policy Statement above and have read a copy of the Woodbridge Eye Care HIPAA Privacy Policy.

SIGNATURE _____ DATE _____
Signature of Patient (or parent if a minor)