



Financial Policy & Patient Responsibility

This agreement establishes the financial relationship between **Eye Disease Consultants, LLC** and the **Patient** and/or **Guarantor**. By signing below, you acknowledge and agree to the following terms:

1. Financial Responsibility

- **Final Responsibility:** The undersigned maintains **final responsibility** for the payment of all services rendered **by our providers**, whether performed in the office, a hospital, or an ambulatory surgery center (ASC).
- **Insurance Submission:** As a service to you, we will submit claims to your insurance carrier. However, you are responsible for any portion of the bill **not covered** by your insurance contract, including co-payments, deductibles, and co-insurance.
- **Insurance Verification:** It is your responsibility to verify with your insurance carrier which services are covered under your specific plan. While we can confirm if we are in-network with a general insurance group, we cannot guarantee how your individual plan will process specific claims.

2. Payments Due at Time of Service

- **Co-pays:** All co-payments must be paid at the time of service.
- **Self-Pay:** If you do not have insurance, or if we are out-of-network for your plan, full payment is required at the time of your visit.

3. Appointment Cancellation Policy

- **24-hour Notice:** To provide the best care for all our patients, we require **at least 24 hours' notice** for any cancellation or rescheduling of appointments, barring a documented emergency.
- **\$45.00 No-Show Fee:** Failure to provide notice will result in a **\$45.00 fee**. We encourage you to call as soon as possible, even up to your appointment time, to allow us to assist other patients. This fee is your personal responsibility and cannot be billed to insurance.
- **Practice Discharge:** To ensure timely access for all patients, **repeated missed appointments** may result in a formal discharge from the practice.

4. Authorizations

- **Assignment of Benefits:** I authorize my insurance carrier to make payments directly to **Eye Disease Consultants, LLC** for services rendered.
- **Communication:** I consent to be contacted via phone, text, or email regarding appointment reminders and billing matters.

Patient/Guarantor Name (Printed): _____

Signature: _____ **Date:** _____