Pocono Eye Associates, Inc.

Statement of Financial Accountability

Thank you for choosing Pocono Eye Associates, Inc. for your eye care needs. We will make every effort to ensure that you are provided with quality eye care and products at reasonable prices.

All charges incurred by the patient, whether for medical services, surgical services, or ophthalmic products are the SOLE RESPONSIBILITY OF THE PATIENT, unless such charges are for services or products covered by an insurance plan in which Pocono Eye Associates, Inc. is a participant. There will be a $25.00 charge if you fail to show for any scheduled appointments or cancel the same day as your appointment. If for any reason a check is returned, you will be subject to a $35.00 returned check fee.

If we do not participate in your insurance, you are responsible for the full amount of charges made. We will help you fill out your insurance forms, but we expect you to make full payment at the time services are rendered. Even if we participate with your insurance, you may owe co-payments or deductibles, non-covered services, or if for any reason your insurance company does not make payment for services rendered, you are still responsible for the balance. If your account is referred for collection, you agree to pay all costs of collection and expense including attorney or agency fee equal to 33 1/3 % of all sums due and payable.

I understand the above statement and acknowledge my responsibility to pay for services rendered at the time they are provided.

_____ _____

Patient's Printed Name **Patient's Signature**

_____ _____

Date **Patient's Guardian (if patient is a minor or POA)**

I hereby authorize the release of any medical or other information necessary to process my claims. I also authorize payment of medical benefits from my insurance company to Pocono Eye Associates, Inc. for any services or products furnished to me.

Signature (Patient or Guardian)_____ **Date:**_____

MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made to Pocono Eye Associates (PEA), Inc. for any services or products furnished to me by PEA. I also authorize Pocono Eye Associates, Inc. to release to the Health Care Financing Administration (HCFA) or its agents any information needed to determine these benefits or the benefits payable for related services or products. I request that payment of authorized "Medigap" benefits be made either to me or, on my behalf, to Pocono Eye Associates, Inc. for any services or products furnished to me by PEA. I authorize Pocono Eye Associates, Inc. to release any medical information needed to the appropriate insurer to determine benefits payable under such a "Medigap" policy.

Signature_____ **Date**_____

MEDICAID PATIENTS ONLY

I request that payment of authorized Medicaid benefits be made to Pocono Eye Associates (PEA), Inc. for any services furnished to me by PEA. I also authorize Pocono Eye Associates, Inc. to release to the Health Care Financing Administration (HCFA) or its agents any information needed to determine these benefits or the benefits payable for related services. I authorize Pocono Eye Associates, Inc. to release any medical information needed to the appropriate insurer to determine benefits payable under policy. I understand that any fees for –services NOT covered by my medical assistance plan are due and payable by me. Eligibility of benefits was explained to me prior to services rendered.

Signature_____ **Date**_____