Dr. Irwin R. Dudow

FINANCIAL RESPONSIBILITY FORM

Assignment of Benefits

PLEASE READ CAREFULLY BEFORE SIGNING

Our practice is committed to providing you with the highest quality of patient care. The following is a statement of our financial policy which we require that you read and sign prior to any treatment being rendered.

(Note: All patients must complete our "Patient Information Form" prior to seeing the doctor.)

Private Payment Patients:

If you do not have a valid insurance plan to cover the costs of our services you will need to make full payment at the time of service. We accept cash, checks, or credit cards. Other payment arrangements may be arranged with the practice administrator prior to treatment.

Insurance Patients:

- I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Irwin R. Dudow, O.D. on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the CMS-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.
- This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.
- I understand that if I receive any payments due to Dr. Irwin R. Dudow, it is my responsibility / obligation to immediately remit the payments to Dr. Irwin R. Dudow. I further realize that if I fail to do so, I am responsible for the bill in its entirety.
- **If my insurance benefits are canceled, and I continue to receive services, I agree to pay all bills in full.**
- I also agree to cooperate with my insurance company in submitting all forms they request. Should I fail to do so, and thus payment is denied, I agree to pay the bill in its entirety.
- **INSURANCE COVERAGE does not necessarily mean FULL coverage, and I understand that I am personally responsible for all co-payments, deductibles and charges beyond my insurance covered benefits**.

Missed Appointments:

Due to our efforts to accommodate all patients when they need to be seen, we ask that if you are unable to keep your scheduled appointment, you cancel no later than 24 hours in advance. We understand that although circumstances at times may prevent doing this, after a second missed appointment we may add a $25.00 missed appointment charge to your account.

I/We further agree that the account may be placed for collection when it becomes 60 days past due and I/We agree to pay all collection costs incurred plus all amounts for service and/or materials due at the time of collection.

Signature of Acknowledgement:

- I realize that I am responsible for payment of all vision care, medical services and materials rendered to me and/or my dependents, upon receipt of service or materials regardless of the decision of reimbursement made by my insurance carrier.
- I hereby acknowledge that I have read the above, or have had the above read to me, and that I understand the terms of this agreement.

PATIENT'S NAME:_____

RESPONSIBLE PARTY / INSURED'S SIGNATURE : _____ DATE: _____