



## FINANCIAL RESPONSIBILITIES

At Eye Doctors of Washington, you can expect to receive medical services in a professional and caring manner. We are committed to providing you with the highest level of service and quality care. In return, it is your responsibility to provide your insurance information. Please have your photo identification and current insurance information available at your visit to ensure that your claim can be processed promptly.

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**1. APPOINTMENTS:** We request that you keep scheduled appointments and arrive at the appointed time. If you are unable to keep your appointment, please give at least 48 hours notice. Cancellations of less than 24 hours prior to your appointment, or a No-Show for your appointment, will result in a \$25 fee per patient.

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**2. CO-PAYS:** According to your insurance contract, you are obligated to pay any co-pay due at the time of service. If you are unable to pay the co-pay at the time of service, we retain the right to cancel or reschedule your appointment to a time when you are prepared to pay your co-pay. Furthermore, if your appointment is kept without payment of the co-pay at the time of service, we retain the right to levy an administrative charge of \$10 to your account in order to defray the cost of securing the co-pay.

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**3. PRESCRIPTION REFILLS/FORMS:** Please request any prescription refills and present any forms that need to be completed at the start of your examination. At that time, we have full access to your complete record and can fulfill your request. When we have to provide these services at another time, there is a \$25 fee to cover the time and effort required to retrieve and review your medical record, verify information and then process your request by telephone, mail or facsimile.

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**4. REFERRALS:** If your insurance plan requires a referral, the referral must be presented before seeing the physician. If you do not have the required referral, we reserve the right to reschedule your appointment or you will have to be willing to be responsible for the entire cost of the examination.

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**5. RETURNED CHECKS:** Any payment made by check that does not clear your bank account will result in a fee for insufficient funds. Our fee for insufficient funds is \$25 and will be added to your account for each bounced check.

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The physicians and staff at Eye Doctors of Washington appreciate your confidence in allowing us to participate in your eye care.

Your signature indicates that you have read, understand and agree to the financial responsibilities policies and procedures of our office.

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Signature of Patient

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Date