EYE CENTER
OF THE NORTH SHORE
EYE PHYSICIANS & SURGEONS
400 Highland Avenue
Salem, MA 01970
978-744-1177

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Eye Center of the North Shore. We are honored by your choice and are committed to providing you with the highest quality care. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- The patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.
- It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.
- If you have no insurance, payment for an office visit is to be paid at the time of the visit.

- **Patients are responsible for the payment of co-pays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan. This may include but not be limited to a "Routine Eye Exam" and /or "Refractions" Currently prices are $290.00 -$390.00 for a new Patient and $150- $325.00 for an Established patient. Refraction cost is currently $35.00. We will bill you after we hear from your insurance. If you prefer to pay in the office, we accept cash, check, money orders and all major credit cards.**

PATIENT/Parent or Guardian SIGNATURE_____ **Date**_____

ASSIGNMENT OF BENEFITS

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services or as the responsible party for minor patients. I hereby authorize my insurance benefits to be paid directly to Eye Center Of The North Shore. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms for one full year from the date signed.

Patient Name (Please Print)_____ Date of Birth _____

Patient Signature_____ Date_____

Responsible Party Name (If patient is a minor)Print _____

Responsible Party Signature_____ Date_____