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PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Rocky Mountain Eye Center, Inc. (RMEC) and/or Pueblo Surgery Associates, LLC (PSA) as your eye care provider. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- You are responsible for the payment of your treatment and care.
- If the patient is a minor, then as the patient's guardian you are ultimately responsible for payment of the minor's treatment and care, even if you are not the carrier of your child's insurance policy.
- If you have insurance we will bill your insurance for you. However, for every visit, you are required to provide correct and updated information regarding insurance.
- You are responsible for payment of:
 - Co-payments
 - Co-insurance
 - Deductibles
 - All other procedures or treatments not covered by their insurance plan.
- Co-payments are due at the time of service.
- Co-insurance, deductibles and non-covered items are due within 30 days from receipt of billing.
- If you do not have insurance, you are responsible for payment for your treatment and care. Payments made on the day of service may be eligible for a same day pay discount.
- If you are here for a Workers' Compensation visit, you must provide appropriate employer and billing information for use to process the claim. Without this information, we will consider payment for the visit to be your responsibility.
- You may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
 - Charge for returned checks

By my signature below, I hereby acknowledge that I understand that I am responsible for full payment (less any adjustments that RMEC/PSA is contractually required to make) within 30 days of receipt of my statement. I understand that I am financially responsible for charges not covered by my insurance.

I have read, understand, and agree to the provisions of the Patient Financial Responsibility Form.

Name of patient (please print)

Date of Birth

Signature of patient or guardian

Date