



KIRMAN EYE

29 West Main Street, Hummelstown, PA 17036, (717)566-3216

FINANCIAL POLICY AND RELEASE OF BENEFITS

The Doctors and Staff at Kirman Eye are pleased that you have entrusted us with your eyecare. We participate with Capital Blue Cross, EyeMed, HealthAmerica, Highmark Blue Shield, Medicare, Geisinger Health Plan, Davis, NVA, Vision Benefits of America (VBA), Vision Service Plan (VSP), Vision Advantage and the InfantSee program. **If you have an insurance company with whom we do not participate, or you have a plan listed above from which we are excluded, 100% of the total cost is required when services are rendered.** For all patients, a 50% deposit is required for any materials ordered with the balance due at the time of receipt. We accept cash, check, Master Card, VISA, Discover, and American Express as methods of payment. Our office does not submit to secondary plans.

Insurance is a contract between you and your insurance company. It is your responsibility to understand the extent and limits of your coverage, and to provide our staff with accurate information to process your claim efficiently (i.e. copy of your insurance card, insurance forms, insurance company, address, phone number, etc.). It is not our place to enter into disputes between you and your insurance company regarding deductibles, co-payments, etc. other than to provide factual information.

We are committed to providing you with the best possible care, and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship.

YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.

With regard to appointments, if you are unable to make your scheduled appointment, please give 24 hour notice as a courtesy to other patients who may require care.

RELEASE AND ASSIGNMENT OF BENEFITS

I hereby authorize Kirman Eye to release to my company or its representative any information including the diagnosis and the records of any treatment or examination rendered to me.

Vision Insurance

Medical Insurance

I AGREE TO THE TERMS AND CONDITIONS PRESENTED ABOVE.

Patient's Name

Signature Patient / Guardian

Date