Hazel FAMILY EYECARE

930 Marietta Hwy, Suite 400- Roswell, GA 30075

INSURANCE AUTHORIZATION AND FINANCIAL AGREEMENT

Providing the best possible eye care involves a mutual understanding between patient and provider. Should you have any questions regarding the following policies, please ask for clarification. Our professional services are rendered to you, not our insurance company. Ultimately, payment for our services is your responsibility.

- I authorize Hazel Family Eyecare to release any information regarding my care to expedite claims or for records transfer should such events be required.
- I hereby authorize Hazel Family Eyecare to bill my insurance company for services provided to me and with payment made directly to the providing doctor's office and that such authorization is valid until written notice is provided to cancel that authorization.
- **While Hazel Family Eyecare makes considerable effort to verify my insurance coverage, benefits, and cost shares, I understand that such information is NOT an official or legally binding estimation of my out-of-pocket expenses. Ultimately, my final cost share is dependent on the decision of my insurance carrier. I UNDERSTAND THAT ANY COPAY ESTIMATES GIVEN TO ME PRIOR TO MY EXAMINATION MAY TURN OUT TO BE DIFFERENT FROM THE FINAL DECISION OF MY INSURANCE CARRIER AND I AGREE THAT I AM DIRECTLY AND FULLY RESPONSIBLE TO HAZEL FAMILY EYECARE FOR PAYMENT OF ALL CHARGES, INCLUDING ANY AMOUNT IN EXCESS OF PREVIOUS COPAY ESTIMATES. I realize that if my insurance company fails to pay its anticipated balance in full or payment is not made within 45 days it is my responsibility to pay the doctor's bill and that I will pay associated fees for the purpose of collection on delinquent accounts.**
- In the event that I receive payment from my insurance company for services provided in this office, I agree to endorse any received payment to the doctor's office.
- **I understand there may be medical findings during the course of my exam. I understand it is a VIOLATION of Hazel Family Eyecare's provider agreement with my insurance to bill such medically related services to my vision wellness plan. In this event, my medical insurance will be billed and I understand I will be responsible for any applicable co-pays, cost-shares, and/or deductibles as per my medical findings in order to bill my vision wellness plan, as that would put Hazel Family Eyecare in direct conflict with its ethical obligations to the Georgia Board of Optometry.**
- I understand there is a $30 fee for all returned checks.
- **We strive for 100% patient satisfaction with all services and products; however we have a no return policy on all eyewear and exchanges are subject to a 20% restocking fee plus any incidental charges with remaking the prescription lenses.**

I understand and agree to all statements made herein and understand this is a legally binding agreement.

Print Name: _____ Date of Birth: _____

Signature: _____ Today's Date: _____