TIFFANY CHAN, O.D.
GERALD D. CHAN, O.D.
JOEL MUNOZ, O.D.

PATIENT FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

Please review, initial, and sign the following below:

- **JANUARY 1ST 2024** I understand that there will be a fee of $50 for last minute changes, including cancelations, for appointments within 48 hours of the appointment time. ___
- I understand that any outstanding balances must be paid prior to scheduling any appointments. ___
- I understand my portion is due in full at the time services are rendered unless other arrangements have been made in advance. ___
- I understand that delinquent accounts (45+ days overdue) will be sent to collections. __
- I understand that there will be a fee of $25 on all returned checks. ___
- I give permission to have my insurance carrier billed on my behalf and that payment will be made directly to this office. ___
- I understand that benefits quoted by this office are an estimate and that only my insurance company can determine actual benefits, and only after receipt of a claim. ___
- I understand that insurance plans vary and there may be limitations and exclusions in my plan of which my doctor may not be aware. ___
- I understand that this office accepts the charge determination of my insurance carrier as the full charge and that I am responsible for the deductible, co-insurance and non-covered services. ___
- **I understand I am financially responsible for charges not covered by my insurance plan. ___**

Print Patient Name:_____

Signature:_____ *Date:*_____

If patient is minor, print name of signer:_____