TIFFANY CHAN, O.D.
GERALD D. CHAN, O.D.
TINA KHIEU, O.D.

PATIENT FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

- 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:_____