Pendleton Family Optometry
765-778-7524

Consent for Insurance and/or Patient Financial Responsibility

We are committed to providing you with the best possible care. We will submit your insurance claim if we are in network with your plan (this includes Medicare). If we are not in network with your insurance, you are responsible for submitting your claim for reimbursement. **Regardless of whether you have insurance or not,** all applicable fees, co-payments and/or deductibles are due at the time services are rendered. We accept Visa, Mastercard, Discover, American Express and Care Credit, as well as checks and cash. Overdue balances are subject to additional costs including, but not limited to, collection fees and attorney fees. We will charge $35 for returned checks.

I hereby authorize Pendleton Family Optometry to apply for benefits on my behalf for covered services rendered. I also assign my benefits and request that all payments from my insurance carrier, including Medicare, be made directly to Pendleton Family Optometry. I agree to assume responsibility for full payment pending any remaining balance that is not covered by my insurance.

I certify that the information I have reported regarding my insurance coverage is correct. I further authorize Pendleton Family Optometry to release information to the insurance provider and/or agents in order to process my claim.

_____
Patient Name (Printed)

_____ _____
Patient Signature Date