PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Dr. Amanda Misinco, O.D. as your eye care provider. Please read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

• The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for his/her treatment and care.
• We are pleased to assist you by billing for our contracted insurers. However, the patient is required to provide us with correct and updated information about his/her insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.
• Patients are responsible for the payment of co-pays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service. For your convenience, we accept cash, check, and most major credit cards at our office.

Patient Authorizations

• I hereby authorize the release of medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.
• I hereby authorize the assignment of financial benefits directly to Dr. Amanda Misinco, O.D. for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

_____ _____
Signature of Patient or Guardian Date

Waiver of Patient Authorizations (For patients not billing insurance.)
I understand that I am responsible for the payment of my treatment and care, and that payment is due at the time of rendered services. I do not wish to have information released on my behalf to any insurance company, and will submit any claims to insurance at my own discretion.

_____ _____
Signature of Patient or Guardian Date

PUPIL DILATION

Eye dilation is recommended every 1 to 2 years to fully assess the health of your eyes. Dilation of the pupils allows a comprehensive evaluation of the back of the eye and aids in the diagnosis and monitoring of various eye conditions. This may include cataracts, glaucoma, macular degeneration, diabetes, and retinal detachment. A dilated eye exam is typically indicated for patients with a previous diagnosis or family history of diabetes, high blood pressure, high cholesterol, glaucoma, retinal detachment and macular degeneration. Dilation can also help determine a more accurate prescription in young patients. Side effects typically last from 3 to 6 hours, and include sensitivity to bright lights and blurry near vision. Most patients are able to drive, but extra caution is advised (consult with Doctor). Eye dilation is considered part of your comprehensive eye exam.

□ **Yes**, I accept to have my eyes dilated today.

□ **No**, I decline pupil dilation.

_____ _____
Signature of Patient or Guardian Date