Patient Responsibility Form

Insurance

- The patient is responsible for providing Philip S Aubrey OD with the most correct, active and updated information about their insurance prior to each visit.
- Philip S Aubrey OD will bill to the insurance most recently provided by the patient with the assumption it is current. If the information given by the patient is inaccurate and denied, the patient will be responsible for the balance of the visit. Please be aware that all insurance companies have timely filing deadlines so providing correct information at the time of service is critical. Timely filing means the patient's insurance plan may not pay for the claim after a certain amount of time after the service.
- Patients are responsible for the payment of co-pays at the time of service.
- Patients are also responsible for paying any applicable co-insurance, deductible and all other procedures not covered by their insurance plan.
- The patient is responsible for knowing what their plan does or does not cover. If the patient has questions about their plan and what services are covered, they should contact their insurance.
- In the event the patient's health plan determines a service to be "not payable", the patient will be responsible for the complete charge and agree to pay the costs of all services provided.
- Philip S Aubrey OD is not responsible for knowing what each individual patient's insurance plan does or does not cover.
- The patient's health insurance policy is a contract between the patient and their Health Insurance Company or employer. It is the patient's responsibility to know if their insurance has specific rules or regulations, such as the need for referrals.
- The patient is responsible for knowing if Dr. Aubrey is in-network with their insurance plan and if the services are covered under the patient's plan.
- I hereby authorize vision care providers to apply for benefits on my behalf for covered services rendered by them. I also assign my benefits and request that all payments from the vision care plans be made directly to the vision care provider. I agree to assume responsibility for full payment pending any remaining balance that is not covered by the vision care plans.

Billing

- If the patient owes additional money after their visit, they can expect to receive a statement.

_____

Printed name of Patient

_____ _____

Signature of Patient or Parent/Guardian Date

_____

Offered

PTRSPON 5/18