VISION SOURCE
MUSTANG

Patient Financial Responsibility Statement

You are ultimately responsible for payment of all services arising out of your care and you guarantee payment for these services. We accept Cash, Check, Care Credit and most major credit cards for your convenience.

Private Pay: If you do not have insurance, payment is due at the time of service. We require 100% of the balance to be paid at the time of service.

Insurance: Although we are contracted with most insurance companies, it is your responsibility to make sure that Dr. Jason Dobson, OD participates in your specific plan. If he is not, you may still select our office for your medical care. "Out of Network" benefits will apply. It is your responsibility to know your insurance benefits. Please contact your insurance company at the customer service phone number printed on your insurance card if you have any questions pertaining to your coverage.

As a courtesy to our patients, we will file insurance claims from our office. We require all information to be completed on the New Patient forms. We must have your insurance information prior to your appointment to verify insurance coverage before your appointment. You must present your insurance card and photo ID at each appointment. If you provide the correct insurance information to our office in a timely manner, we will file a claim on your behalf. By signing this form, you authorize Dr. Jason Dobson, OD to file insurance, including secondary insurance, on your behalf for eligible services, treatments, and and/or materials. You further authorize any holder of personal health information about you to release to your health insurance company(ies) any information needed to determine these benefits or the benefits payable for related services.

Billing: If you receive an invoice from our office for a balance due, it is the balance your insurance policy requires you to pay.

Collections: Invoices not paid within 60 days will be considered late and subject to collection services.

Returned Checks: If your check is returned to us for any reason, you will be charged a fee of $30.00. If the total balance due is not paid within 30 days from being returned by our bank, it will be turned over to the Canadian County District Attorney's office for collection.

_____ _____

Patient Name (Printed) Patient Signature

_____ _____

Financial Responsibility Party Name (Printed) Financial Responsibility Party Signature

_____

Date Signed