# FINANCIAL AGREEMENT

I understand that as a courtesy to me, the optometrist's billing staff will file all claims for services rendered to my insurance carrier.

I, however, acknowledge that I am responsible for any balances that may be due to the optometrist because of:

- Co-insurance or co-pay amounts
- Yearly deductible
- Non covered services
- Out of network charges
- Terminated coverage
- Exhausted auto benefits
- No insurance coverage
- Failure to respond to insurance carrier correspondence
- Failure to respond to coordination of benefits inquiry

I _____ agree to pay any charges not covered by my insurance. This amount may be more than the 30% that I have already paid. We as your eye care provider will be happy to file your insurance claim, but it is ultimately your responsibility to work with your insurance company to get claims paid if problems arise.

Date:_____

Signature:_____