Patient Financial Responsibility Contract
Silverstein Eye Centers, P.C. Financial Agreement

At Silverstein Eye Centers, P.C., our commitment to providing professional and compassionate care is matched by our expectation for responsible patient conduct. This extends beyond punctuality and cancellations; it includes financial responsibility. To ensure clarity and fairness, we ask you to review and acknowledge the terms outlined in this Patient Financial Responsibility Contract.

This agreement serves as a binding contract between Silverstein Eye Centers, P.C. and you, the patient. The terms 'I', 'me', 'my', 'you', and 'your' all refer to the patient.

1. **Financial Responsibility for Services:**
   I acknowledge my financial responsibility for the payment of services rendered by Silverstein Eye Centers. I understand that I can settle these charges using cash, check, or credit card.

2. **Presentation of Insurance Cards:**
   I agree to present my current insurance cards during each office visit. I understand that any balance remaining after my insurance has made its payment on my claim is my responsibility, and I will make the necessary payment upon receipt of a statement.

3. **Accurate and Complete Insurance Information:**
   I commit to providing Silverstein Eye Centers with accurate and complete information regarding my primary and secondary insurance medical benefits, including referral documents from other providers if required. I am aware that providing incomplete or inaccurate information may lead to claim denial or delayed payment. I accept the responsibility to pay any balance on my account after insurance claim processing.

4. **Referral Requirements:**
   In the event that my insurance requires a referral, and such referral is not secured prior to my appointment, I agree to either pay an estimate of charges in advance or reschedule my appointment.

5. **Missed and Cancelled Appointments:**
   I understand that any missed appointments or cancellations with less than 24-hour notice will incur a fee of $50.00.

6. **Returned Check Fee:**
   I am aware of the $35.00 fee for all returned checks.

7. **Insurance Coverage and Payment:**
   I acknowledge that my insurance may not cover all services or may deny payment for approved services. I agree to pay any remaining balance after insurance processing.

8. **High Deductible Policies or No Insurance:**
   If I possess a high deductible policy or lack current insurance benefits, I agree to pay an estimated charge for my office visit in advance, understanding that additional charges may apply.

9. **Co-payments and Deductibles:**
   I agree to make co-payments and deductibles at the time of service. Failure to do so might result in rescheduled appointments.

10. **Address and Contact Information:**
    I acknowledge the importance of keeping my contact information current. Failure to provide accurate address and contact details may lead to further actions to recover unpaid balances.

11. **Delinquent Accounts and Collection:**
    If my account becomes delinquent, I understand that it may be transferred to an external collection agency without notice. I acknowledge my responsibility for covering all collection-related costs, including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency fees.

I have read and understood the financial policies of Silverstein Eye Centers, P.C. I accept full responsibility for any fees associated with my care.

Patient Name: (Print) _____

Patient Signature: _____ Date: _____