**Patient Financial Responsibility Disclosure Statement**

Eye Was Framed Optical Ltd.

11319 West 143rd Street

Orland Park, IL 60467

708-460-2020

**All charges for services rendered are due and payable at the time of service**

A note from Eye Was Framed (EWF) regarding your Medical and Vision Insurance: We have contracts with many insurance companies, and we bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay us for any reason.

The person signing on behalf of the patient as the responsible party must:

* Inform EWF of the current address and phone number for the patient and the responsible party.
* Present all current insurance cards prior to each office visit.
* Verify at each visit that the information is current by signing our data sheet.
* Pay any required copay at the time of the visit.
* Pay any additional amount owed within 30 days of receiving a statement from our office. Finance charges will be incurred after 30 days. *(When EWF receives an explanation of benefits (EOB) from your insurance company, any additional amounts that you need to pay will be billed to you.)*

**Non-Payment on Account**

Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient’s Responsible Party understands that EWF has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient’s Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, interest due at 18% APR, all court costs and Attorney fees, and a collection fee added to the outstanding balance.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services, or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Type of Vision Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Medical Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (Please Print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party Name (Primary on Insurance) (Please Print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_