Cullison Eye care

Consent for Treatment / Financial Responsibility Statement

By signing this form, you consent to treatment for yourself and /or the minor for which this information pertains. You give permission for the doctor and staff to examine, diagnose and initiate treatment as deemed appropriate. You also agree to be financially responsible for any treatment or services provided as described below.

If you have vision benefits, we will be glad to help you file your insurance claim forms or take assignment for your vision benefits. This service will be provided without additional charge to you. We will also do all that we can to assist you in receiving maximum benefits.

In the event that the plan sponsor determines that you are not eligible at the time of service or eligible only for a reduced level of coverage, you do hereby agree to be financially responsible for any and all of the charges incurred by you and not paid by the plan sponsor by signing this statement. This includes any additional charges you may incur for contact lens services such as the contact lens fitting. If your vision benefits cover, or require a copayment for this service, you will be charged according to your plan.

If you are not using vision benefits, you agree to be financially responsible for any charges incurred from diagnostic testing and materials purchased. This includes any additional charges you may incur for contact lens services such as the contact lens fitting.

If you are utilizing medical insurance for your visit and have not yet met your annual out of pocket deductible, you do hereby agree to be financially responsible for any and all of the charges incurred by you and not paid by the plan sponsor by signing this statement. If your medical benefits cover, or require a copayment for this service, you will be charged according to your plan.

Individuals wishing to utilize their flexible spending account must present the card at the time of payment for services or materials. If another form of payment is made initially, this payment cannot be refunded and applied to a flexible spending account at a later time.

**All glasses are custom made and therefore all sales are final.

Patient's Name: _____

_____

Patient's Signature Date

_____

Legal Guardian (If patient is under 18 years old) Date