Financial Consent Form

By signing my name below:

I hereby guarantee payment in full within thirty (30) days of all charges established by Dr. Angela Berghoff and StylEyes for services and materials rendered to me, unless other arrangements satisfactory to Dr. Berghoff and StylEyes have been made. This includes any changes that a third-party payer may determine to exceed usual and customary limits.

The copy of my insurance card is current and has the correct insurance information. If I sign this form and the insurance card is found later to be outdated or invalid, I understand that I am responsible for paying for the services and materials in full and will need to file to the insurance carrier myself.

The applicable co-pay (s) will be paid at the time of service, per my insurance company policy.

I understand and acknowledge that if any unpaid amounts owed by me are assigned to a third party for collection, I will be responsible for paying attorney fees, interest, court costs, and other costs of collection, including collection agency fees.

I authorize Medicare, Medicaid, Blue Shield and all other commercial payers to pay St. Vincent Hospital and StylEyes on my behalf for any services and materials furnished to me by the provider (s).

This form will also give authorization for my physician to release any medical information necessary to process any insurance claims, for treatment, and for general health care operations. This includes, allowing the release of information to any specialty care provider or entity that I am referred to.

I certify that I have read this assignment of benefits, that the information given by me is correct, and that I agree to all of the provisions contained in it.

______________________________ ____________________

Patient Signature Date

Update: Please notify us of any corrections and then initial and date below. This will indicate that you have reviewed and updated your Patient Information.

Initials	Date	Initials	Date	Initials	Date
Initials	Date	Initials	Date	Initials	Date
Initials	Date	Initials	Date	Initials	Date