Day Optometry Clinic P C
137 W Shugart Ridge Road
Gardendale, Al 35071-2671
(205)631-5681

Guarantee of Payment, Financial Agreement, Privacy Notice, Consent for Medical Treatment, And Release of Information.

1. **Guarantee of Payment of Account:** I authorize Day Optometry Clinic, P.C. to keep my signature on file and to charge my credit card on record for all remaining balances after insurance claims is/are resolved. **This includes co-pays, deductibles, glasses, contact lenses, and any denied claims.**

2. **Financial Agreement:** I understand that I am responsible for all charges at time of service and that there is no guarantee of payment from any insurance company or other payer. I understand that some routine services are not covered by my insurance and that I am financially responsible for all charges at time of service. I agree to pay all charges for the services provided by Day Optometry Clinic P C which are not paid by my health insurance or other payer. I authorize Day Optometry Clinic P C to keep my signature on file and to charge my credit card on record for all remaining balances after insurance claims is/are resolved. This includes co-pays, deductibles, glasses, contact lenses , and any denied claims. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that I am responsible for a $25.00 returned check fee in addition to any other associated bank charges.

3. **Assignment of Insurance Benefits:** I hereby assign and request that payment of all insurance benefits be made directly to Day Optometry Clinic, P.C. Furthermore, I understand that I am financially responsible for any and all charges incurred while under the care of this office.

4. **Consent for Treatment:** I consent to necessary treatment including drugs, medicine, performance of in-office procedures, or other studies and tests that may be used by the doctors and staff.

5. **Authorization for Release of Information and Privacy Statement Notice:** Day Optometry Clinic P C may release information from my medical records to any health care provider involved in my care and treatment. Day Optometry Clinic P C may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, workers' compensation carrier or my employer who is providing payment due to injury on the job. I have received notice that Day Optometry Clinic, P.C. abides by HIPAA privacy policy.

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Signature of Patient *or Legally Responsible Person*