

The Regional Eye Center

**135 W Ravine Road, Suite 2C
Kingsport, TN 37660
Phone: 423-246-7372
Fax: 423-246-5038**

Financial Policy

Responsibility for Payment of Medical Services

I understand it is my responsibility to notify **The Regional Eye Center** of my Insurance coverage, and any changes in or special requirements of my insurance coverage. I understand that I am ultimately responsible for all fees related to my care. Regional Eye Center will, in most cases, file claims for services provided.

Co-Pays and Deductibles must be paid at the time of service; also, any fees for non-covered services or products will be due at time of service.

Payment will be due at time of service for Self-Pay patients, those with no insurance or insurance plans that The Regional Eye Center does not participate in.

The Regional Eye Center does NOT bill or file claims to any third parties (auto insurance, lawsuits, accidents, worker's comp, etc). The Regional Eye Center will provide you with all the necessary information that you will need to file yourself, and payment is due in full at time of service for these services.

Please ask questions if you do not understand regarding fees, and we will be glad to assist you.

Patient Signature or Authorized Representative

Date

Present Insurance Card

*Name of PRIMARY Covered on Insurance _____

*Are you ____ Primary or ____ Dependent or ____ Spouse

*Birthdate of PRIMARY on card _____

*Must have to file insurance