ACCOUNT PAYMENT AGREEMENT FORM

By signing the form below you are agreeing to the following:

I acknowledge that payment is due at the time of treatment. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor child. I accept full financial responsibility for all charges not covered by insurance. I understand that I am responsible for any co-payment, deductible, co-insurance and non-covered services.

I, the undersigned, agree to be responsible for the balance of my account. Although an insurance claim (if applicable) will be filed with my insurance company by the doctor on my behalf, negotiating payments through my insurance company ultimately is my obligation. If my insurance company requires a referral/authorization from my Primary Care Physician, I understand it is my responsibility to obtain this. If I have no insurance, I understand that payment will be made at the time the services are rendered.

I hereby authorize Gelner Optometry, P.C. to:

- Administer medical treatment as necessary for a patient in my condition.
- Release any and all information contained in my medical records pertaining to this treatment or series of treatments to my insurance company, third party carriers, or their representatives, and referring or consulting physicians.
- Authorize payments of medical and vision benefits, provided by my insurance carrier, to Gelner Optometry,PC.

Signed: _____ Date: _____

Patient Name/Parent, if Minor