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palmereyecarepc.com

Financial Responsibility - Signature on File

We are happy to file insurance claim forms or take assignment on your medical/vision plans for which we are providers and which state you are a member. We will do all we can to help you receive maximum benefits. However, in the event that the plan sponsor determines that you are not eligible for coverage at the time of service, or makes a determination that you are eligible for a reduced level of coverage, by signing this statement you hereby agree to be financially responsible for any and all charges incurred by you and not paid by the plan sponsor.

I hereby authorize the processing of the insurance either by electronic or manual method by Palmer Eye Care, PC. I further authorize Palmer Eye Care, PC to release all medical and/or insurance claim information necessary to secure the payment(s). I recognize my financial obligation of any co-insurance, deductible, or non-covered services that may be required.

Palmer Eye Care, PC maintains a contract provider relationship with many insurance and vision plans but not all insurance and vision plans. It is the responsibility of the patient to know if Palmer Eye Care, PC is listed as a provider prior to scheduling an appointment.

This agreement will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as an original. I understand that payment in full may be required at the time of service.

I acknowledge that I am either the patient or I am authorized to act on the patient's behalf.

Patient Signature

Date