HILLSBORO EYE CLINIC, P.C.

HillsboroEyeClinic.com | 503-640-3708

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PATIENT'S RESPONSIBILITY FOR PAYMENT

As a courtesy and service to our patients, Hillsboro Eye Clinic, P.C., will submit chargesfor medical treatment to your insurance company. However, the patient (or guarantor) isresponsible for paying any and all medical expenses incurred at the clinic. If you have aquestion regarding a claim or coverage, please contact your insurance company.If you participate in a HMO or PPO that requires co-payment, you must pay the co-payment at the time of the appointment. Referrals are your responsibility.If you are involved in a motor vehicle or liability accident, you are responsible for payingall medical costs even if there is a pending lawsuit.I understand Medicare will not cover the refraction fee done today by the doctor's atHillsboro Eye Clinic, P.C..

CONTRACTUAL AGREEMENT TO PAY MEDICAL EXPENSES

I understand that I am personally responsible for all medical expenses incurred atHillsboro Eye Clinic, P.C., which are not covered by my insurance company. I agree topay all medical expenses within 30 days of the date I am billed for those expenses, unlessother arrangements have been made with Hillsboro Eye Clinic, P.C.. I understand thataccounts 90 days old are considered delinquent and may be turned over to an outsidecollection agency. If so, I am responsible for all collection fees.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize release of all my medical information to my insurance company and mypersonal physician. I authorize payment of all medical benefits by my insurancecompany to Hillsboro Eye Clinic, P.C..

Patient or Authorized Person Signature
(Parent or Guardian if Patient is a Minor)

Date of Signature