ALAMEDA EYE Physicians

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Patient Responsibilities Agreement Form

We strive to provide high quality patient care and excellent customer service to every patient in our practice. Our goal is to create a long-term relationship with every patient. Schedule management allows us to accomplish this goal. All patients need to be courteous and call our office when it is not possible to make an appointment in order to prevent other patients in need of treatment from being needlessly turned away. We attempt to honor all reserved appointment time slots for all patients. Asking patients to abide by this agreement benefits you, your fellow patients and our practice. Additionally, please also know we are utilizing a new service for appointment reminder communication. This service will utilize email, phone and texting. **When you receive a phone call from the reminder service, please do not just hang up after listening to the message. Instead, please select "1" to confirm the appointment or select "2" to request a rescheduled appointment.**

I, _____ (printed name), agree to the following standards:

1) I agree to attend all scheduled appointments except when a true emergency circumstance occurs. I also understand that if I am more than 15 minutes late to an appointment that my appointment may need to be rescheduled. I understand that if fail to provide at least a 48 hour advance notice for a cancellation or reschedule that I may be subject to $25 Fee for missed office appointments and a $200 Fee for missed surgery appointments. (One grace missed appointment will be allowed before charging.)

_____ (Please Initial)

2) I understand that all fees for services rendered (including insurance copayments and deductibles) are due at the time of service. I understand that if I come unprepared to pay these required fees that I may be subject to additional $35 billing fee for each occurrence. I understand that if I fail to keep my patient account balance current that I may not be allowed to schedule any further appointments and that I am subject to dismissal as a patient. I understand that I am responsible for all non-covered services including denied insurance claims.

_____ (Please Initial)

3) I understand that it is my responsibility to provide the office with my current contact information and insurance billing information if/when it ever changes. I understand that failing to do so may result in a private pay fee due (if insurance denies due to late deadline billing). I also understand that it is ultimately my responsibility to know the coverage and exclusions of my insurance plans. (As a courtesy our office will attempt to assist you with coverage interpretation when possible but ultimately it is your responsibility to know your coverage not ours.)

_____ (Please Initial)

_____ _____

(Patient Signature) (Date Signed)

FAILURE TO SIGN THIS FORM WILL NOT EXCLUDE YOU FROM HAVING TO FOLLOW OUR OFFICE POLICIES. WE WILL STILL DOCUMENT THAT YOU WERE PROVIDED THIS FORM, AND IT WILL STILL BE ENFORCED.