Financial Responsibility Form

245 N. Main St., Suite 300
Springboro, OH 45066
937-748-2955

Vision Insurance	Policy #	Policy Holders Name	Birthdate
Medical Insurance	Policy #	Policy Holders Name	Birthdate

It is your responsibility to know if Springboro Vision Center is an authorized provider according to your insurance contract, and/or if prior-authorization/referrals are required. Please give any forms, insurance cards, and photo I.D to the receptionist. We will bill your insurance company; however, if for any reason your insurance does not pay as expected (which may take up to 120 days or more to determine) you will be billed for outstanding balances and/or uncollected copays. Once notified, there will be a 2% service charge, beginning 30 days from notice date, and every 30 days there is a balance on your account. There will be a $25.00 collection fee added to any outstanding balances turned over to a collection agency. **Professional Services are payable when rendered. A deposit is required on all materials ordered. Balance will be due upon delivery. Deposit will forfeit after 120 days.**

Initial here: ________

Patient Name | Birthdate

Patient Signature | Date

Parent Name (if minor)

Parent Signature (if minor) | Date

Please Note: This form is valid for one year from date of signature