

**DR. KURTBAY OPTOMETRY
750 IRVING STREET
SAN FRANCISCO, CA 94122
415-759-5448**

FINANCIAL AND INSURANCE POLICY:

We are committed to providing you with the best possible service and are pleased to discuss and explain our professional fees with you at any time. Your clear understanding of our financial and insurance policy is important to our professional relationship.

- **24hr notice is required when re-scheduling or canceling an appointment or you will be billed \$50 for failure of notification.**
- Full payment is due at the time of service unless other arrangements are made prior to seeing the doctor.
- For your convenience, our office accepts cash, ATM, and all major credit cards. We do not accept checks.

FOR PATIENT'S WITH VISION INSURANCE:

In our ongoing effort to assist our patients, please present your insurance information prior to services being rendered. We are unable to honor your insurance should you provide the information after the initiation of services.

Our office will be happy to submit your insurance claims. Please understand that your insurance company, not our office, determines your vision benefits.

I acknowledge that it is my responsibility to know and understand my vision insurance benefits. **I agree to be responsible for all fees not covered by my vision insurance or should my insurance company deny payment to Dr. Kurtbay Optometry.**

INFORMED CONSENT AND DISCLOSURE:

I have read, understood, and agree to the above and I authorize "Dr. Kurtbay Optometry" to submit and to sign insurance claims on my behalf. I also authorize the release of any information pertinent to my insurance company or their agents. I understand that this authorization is a direct assignment of my rights and benefits under my policy and that the payments will be paid directly to "Dr. Kurtbay Optometry."

Responsible Party: _____ Date: _____
Print Name

Signature

ALL DELINQUENT ACCOUNTS, IF NOT RESOLVED BY OUR OFFICE IN A TIMELY MATTER, WILL BE FORWARDED TO A COLLECTIONS AGENCY.