1051 E MAIN ST
WAYNESBORO, PA 17268

ANTIETAM
EYE Associates
717-387-5657

717-387-5657 PHONE
717-387-5638 FAX

Please review and *Sign*. Your signature attests that you understand and accept the policy stated below:

Welcome to **Antietam Eye Associates**, we believe that you deserve the best eye care possible. We are pleased that you have chosen our facility for your medical and vision care. Please carefully read and sign the following policies.

Financial Policy Statement

Our office will gladly file for all reimbursement services to primary, secondary, and tertiary medical and/or vision insurances. **Please be aware that you are responsible for all copays at the time of service. As well as deductible (s) and any non-covered service amount (s) determined after your insurance has processed your visit.** Refractions are to be collected at time of service and most medical insurance companies consider this charge as a non-covered service. If you are unable to pay your copayment and/or refraction fee on exam there will be an additional $10.00 fee. As the insured, we expect you to know your coverage, benefits, and responsibilities. While we are here to help, if you have questions regarding your coverage please contact your employer or your insurance company. Understand that while we file your claim with your insurance company (s), our relationship is with **you** and **not** your insurance carrier.

It is the patient's/responsible party's responsibility to provide all necessary contact, referral, authorizations, and current, accurate billing information. **Failure to do so will result in charges for services becoming the sole responsibility of the patient/responsible party.** There will be a $25.00 service charged on all returned checks. I understand accounts 90 days or older are subject to a 33 1/3% collection fee and other incurred costs, which I agree to pay. I am aware that Antietam Eye Associates has patient and optical policies and I understand that they are available to me at any time upon request or on our website @ **Antietameye.com**

Signature **Date**

Dilating Eye Drops

Often my eye doctor will find it necessary to dilate my pupils during my exam. Dilating drops frequently blur vision for some length of time and may make bright lights bothersome. I understand that due to this, driving may be difficult and have made appropriate arrangements. I hereby authorize my doctor and/or his /her assistant to administer dilating eye drops, since dilation may be necessary to diagnose my ocular medical issues.

Signature **Date**