SAN MARINO EYE
WE LISTEN. YOU'LL SEE™

DAVID D. RICHARDSON, MD, INC.
DAVID RICHARDSON, M.D. • MICHAEL PRITCHARD, O.D.
2020 Huntington Drive
San Marino, CA 91108
Telephone: (626) 289-7856
Fax: (626) 284-6532

Financial Policy

Patient's Name: _____ Date: _____

You have chosen to see one of the above specialists for your eyecare. These specialists will provide medical and/or optometric services that may or may not be covered by your insurance. It is important that you understand our financial policy prior to receiving these services.

Dr. David Richardson is no longer accepting insurance payments for his services. This means he is "OUT-OF-NETWORK" and that you will be responsible for payment at the time of service.

As a courtesy to you, at your request, we will help you submit the claim to your insurance company for reimbursement. If your insurance company has out-of-network benefits they will send payment directly to you.

If paying by check, please write "**David D. Richardson, MD, Inc.**" in the "Pay To The Order Of" line.

If paying by credit card, your receipt and statement will indicate that "David D Richardson, MD, Inc." is the vendor regardless of which of the above doctors perform the service.

Once we have established a positive pattern of payment from you we may, at our discretion, allow you to set up a payment plan if you require a procedure resulting in a balance of more than $500.

PLEASE INITIAL, SIGN AND DATE:

General Financial Agreement:

_____I understand that I am financially responsible for all charges.

_____I agree to remit payment in full for services provided at the time of service. If I am unable to pay the balance in full, I will immediately contact the office of David D. Richardson, MD, Inc. to apply for credit or set up a payment plan.

_____I understand that my insurance may not reimburse me for the items or services provided by David D. Richardson, MD, Inc.

I have read and agree to the Financial Policy of David D. Richardson, M.D., Inc.

_____ _____

Signature of patient or person acting on patient's behalf **Date**

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insurance, your health information on this form may be shared with your insurance.