Diana Gonzalez, O.D.
Vision Source
2339 East Evans Road, Suite 104
San Antonio, TX 78259
210-404-2015
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www.visionsource-drgonzalez.com

Thank you for choosing Dr. Diana Gonzalez as your vision care provider. We are committed to providing you with the best available vision care. Our personnel will be pleased to discuss our fees and this policy with you at any time. We ask that you read and sign our Financial Policy prior to seeing the doctor. Payments for services are due at the time services are rendered. We accept cash, check, Visa, MasterCard, American Express, and Discover.

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract. Our relationship is with you. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and "usual and customary" charges.
2. All charges are your responsibility whether your insurance company pays or does not pay. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. Fees for these services, along with unpaid deductibles and co-payments are due at the time of service.
4. If your insurance company does not pay the claim with 45 days, it is your responsibility to contact your insurer to expedite payment. After all, if your insurance does not pay, you are responsible for payment.
5. Returned checks and balances older than 45 days may be subject to collection payment.
6. **INSURANCE INFORMATION MUST BE PROVIDED AT THE TIME OF SERVICE.** Should you find that you have coverage at a later time or date, we will provide you with the needed billing information for your reimbursement claim.

Again, thank you for choosing Dr. Diana Gonzalez as your vision care provider. We appreciate you trust in us and we appreciate the opportunity to serve you.

______________________________ ______________
Patient/Guardian Signature Date

I hereby authorize my insurance company to pay directly to Diana Gonzalez, OD, & Associates, PA, all benefits otherwise payable to me under the provisions of my policy. I hereby authorize the necessary vision information to be released to the insurance company for processing this claim. Photostat copies of this authorization will be considered as valid as the original.

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Patient/Guardian Signature Date

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Patient's Printed Name