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PATIENT FINANCIAL RESPONSIBILITY

Thank you for choosing the Eye Institute of Marin for your medical needs. We are committed to providing you with the highest quality healthcare. We ask you to read and sign this form to acknowledge your understanding of our patient financial policies.

- The patient (or patient’s guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- As a courtesy, we will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for the payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan(s).
- Copays are due at the time of service
- Coinsurance, deductibles, and non-covered items are due 30 days from receipt of billing.
- Patients may incur and are responsible for payment of additional charges, if applicable. These charges may include a charge for returned checks \$25.00.
- By my signature below, I hereby authorize assignment of financial benefits directly to Eye Institute of Marin and any associated healthcare entities for services rendered as allowable under standard their party contracts. I understand I am financially responsible for charges not covered by this assignment.

Patient Name (Print)

Date

Patient/Guardian Signature