Eye Associates of Tallahassee
2020 Fleischmann Road
Tallahassee, FL 32308

Surgical Financial Information Form

I, _____, have been made aware of the following costs due to Eye Associates of Tallahassee **(Collected prior to my procedure),** and Seven Hills Surgery Center **(Collected prior to/or day of surgery).**

I hereby agree to the following financial responsibility according to my Health Insurance Plan. The **ESTIMATED** amounts are applicable for the present date as verified through my insurance company.

Also, I am aware there COULD be additional fees for anesthesia. The facility will forward a claim to my insurance company. If for any reason there is a balance remaining, I will be responsible for that bill.

All fees are due prior to your surgical procedure

*****The following fees DO NOT include any fees/copay's due for your pre-op visit(s) including diagnostic test(s) or Anesthesia fees. *****

Eye Associates of Tallahassee - (Per Eye) Surgeon's Fee/Copay $ _____

If you chose a Custom Vision Package $ _____

Total **estimated** fee(s) owed/paid to Eye Associates $ _____

Seven Hills Surgery Center - (Per Eye) Facility Fee/Copay $ _____

If you chose a Custom Vision Package $ _____

Total **estimated** fee(s) owed/paid to Seven Hills Surgery Center $ _____

Capitol City Anesthesia – **Anesthesia fee/copay** – This is a separate entity. **You/Your insurance company will be billed directly from Capitol City Anesthesia**. If you have any questions, please contact them directly.

Capitol City Anesthesia, LLC
Drop Box: 1204-B Miccosukee Road
Tallahassee, FL 32308
Phone: 850-656-4277 Fax: 850-656-4276
Billing Inquiries: 800-919-1190 ext. 163

Eye Associates of Tallahassee is committed to providing all of our patients with exceptional care.
When a patient cancels without giving enough notice, they prevent another patient from being seen.

Please call our office at 850-878-6161 **72 hours prior to your scheduled surgery** to notify us of any changes or cancellations. **If prior notification is not given, you will be charged a $100.00 fee for the missed appointment**.

I have been notified of estimated fees and cancellation fee: _____

Date: _____

DOB: _____

Surgical Coordinator: _____