Lewis County
Eye & Vision Associates, P.S.

Acknowledgment of Receipt of Privacy Policies (HIPAA):

- I acknowledge that I received a copy of the Notice of Privacy Practices for this office (In Office).

Consent to Treat:

- I hereby give my permission to Lewis County Eye & Vision to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment.

Insurance Authorization:

- I request that payment of authorized Insurance benefits for any services furnished me, be made on my behalf to Lewis County Eye & Vision.
- I authorize any holder of medical information about me to release to my insurance company and its agents any information needed, including third party payers, to determine these benefits or the benefits payable for related services.
- I understand that I am responsible for charges not paid by the insurance plan.
- I understand that I am financially responsible for any remaining balance.

Beneficiary Agreement for Medicare Patients:

I have been notified by my physician that Medicare is likely to deny payment for the services identified below for the reasons stated. I agree to be personally and fully responsible for payment if Medicare denies payment. I understand that, by law, the physician is obligated to bill me for uncovered services.

- Medicare pays for 80% of **covered** services after your deductible is met.
- Medicare does not pay for the refraction portion of an eye examination. Visual fields testing may also not be covered.
- Medicare does not pay for frames or lenses unless the patient has undergone cataract removal surgery. Lens coatings, tints, or other extras above basic bifocals or trifocals may not be covered.
- Routine eye exams are not covered.

Patient Signature on File Card Lifetime Authorization:

- I request that payment of authorized Insurance benefits (including Medicare benefits) for any services furnished me, be made on my behalf to Lewis County Eye & Vision.
- I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

No Show/Same Day Cancellation and Late Appointment Arrivals:

- **Missed appointments or same day cancellations may result in a $25 fee.** (*This fee is not covered by insurance and would be the patient's responsibility)*
- **If you arrive more than 10 minutes late for your appointment, or without necessary paperwork completed, we may need to reschedule your appointment.**

Please see other side
Please see other side

Lewis County
Eye & Vision Associates, P.S.

Financial Policy

- The doctors and staff are committed to providing you with thorough, professional eye care. The following is a statement of our financial policy. If you have any questions please direct them to our staff.
- Acceptable forms of payment include cash and personal checks. Also, for your convenience, we accept Visa, MasterCard, Discover and American Express. Care Credit is another option.

Professional Services:

- Payment for examinations and office visits are expected at the time of service. If a vision insurance plan in involved, your co-payment and/or difference between the fee and your coverage need to be paid at the time of service. Your co-pay for a medical office visit is also due at the time of service.

Materials:

- Our practice is committed to providing you with the highest quality eyewear products available. Because eyeglasses are custom made for your, we require 100% of the patient portion due at time of order. If financial arrangements need to be made, a minimum of 50% deposit is required. Any remaining balance is *due upon delivery*.
- For patients with vision insurance, your co-pay and/or overages are to be paid in full at the time of ordering. We will ship your contacts or glasses to you for a $15 fee. You must be paid in full prior to shipping. A minor child coming to pick up his or her order without a parent does not negate this policy. Please provide your child with a form of payment, or you may call us with your credit card prior to pick up.

Insurance:

- Your insurance contract is an agreement between you and your insurance carrier. Although we participate with many plans, it is the patient's responsibility to make payment in full, should we not participate with your plan or payment is denied by your insurance company. As a courtesy, we will file your insurance today on your behalf. We cannot bill your insurance company unless you give us your **current** insurance information.
- If you do not have vision insurance for services provided, a 10% administrative discount will be given if the account is **paid in full** on the day of service.

Delinquent Accounts/Service Charges:

- A service charge of 1.5% per month will be added after 60 days. This is an APR of 18%. There will be a $15 service charge for any returned check.

After reviewing the preceding information, please sign here that you acknowledge and understand. We will also ask for your electronic signature for our new computer system.

Patient/Guardian signature: _____ Date: _____

Please see other side
Please see other side