

FINANCIAL POLICY / CONSENT AGREEMENT

INSURANCE / THIRD PARTY POLICY:

Today's health care environment has become more confusing and complex. Understanding your health insurance and vision benefit is not as easy as it once was. The insurance relationship is between the patient and the insurance company, **not** between the patient and the provider. Most common insurance programs only cover **part** of the overall eye health examination.

We will submit charges to any insurance company for which we are participating providers. For patients with other coverage, we will help prepare forms and provide any information necessary to assist you in obtaining reimbursement for today's services. If our office does not receive a response from your insurance company within 90 days, you will be responsible for the charges and you will have to recover payment directly from your insurance company.

It may be necessary for your doctor to perform additional special testing to insure the overall systemic health of your eyes. Some of this additional testing may not be covered or included in your co-pay as part of your vision benefit. Payment for these additional special tests is the financial responsibility of each patient.

PAYMENTS:

Payment and/or co-payments for services are due in **full** on the day of service.

Payment and/or co-payments for materials are due in **full** on the day of order.

Acceptable methods of payments are: Cash, Check, VISA, MasterCard, or Discover.

RETURNED CHECKS:

There is a fee of \$25.00 for any checks returned by the bank.

MISSED APPOINTMENT FEE:

The second time a patient fails to keep an appointment, or cancels with less than 24 hours notice, a \$50.00 fee will be charged. This fee must be paid before a new appointment is scheduled.

WAIVER OF CONFIDENTIALITY:

We will release your medical information in order to process third party claims on your behalf. If your account is submitted to an attorney or collections agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office becomes a matter of public record.

NOTICE OF PRIVACY PRACTICES:

Copies of Vision Professionals' *Notice of Privacy Practices* are available at the front desk.

I have read the above conditions of treatment and payment and agree to their content. In addition, I give my permission to Vision Professionals to provide any necessary optometric services for myself or any of my dependents.

Patient's Name: _____

Parent with Child: _____

1. Signature: _____

Today's Date: _____