ADVANCED EYE CARE AND OPTICAL FINANCIAL POLICY

1. I understand all office charges and co-pays are due at the time of service by cash, check, or credit card. Advanced Eye Care and Optical will gladly bill my health or vision insurance for services that my insurance authorizes. If the services billed to my insurance are denied, I am responsible to pay upon receipt of the bill in a timely matter.
2. I acknowledge and agree that an interest rate of 1 ½ percent per month (18% annum) will be charged on all balances that remain unpaid 30 days after said date of service. In the event of default and referral to an attorney or collection agency, I agree to pay all collection costs including reasonable attorney fees.
3. I understand Medicare and other health or vision insurances will only pay for services they are obligated under law or under contract to provide. If Medicare or another insurance denies payment for a reasonable service allowed by law, I understand I am liable for payment for that service.
4. I understand that if I am under Medicare insurance, Medicare does not pay for refraction code 92015. I agree to be personally and fully responsible for payment for that service. I also understand that Medicare does not pay for optical materials (frames, lenses, or contacts) unless immediately after cataract surgery. I agree to pay all material charges, which are allowable, and Medicare does not pay. This includes additional charges for more expensive frames and lenses that I may desire after cataract surgery.
5. I understand that all optical products (glasses and contacts) are custom orders. If I should cancel an order after the manufacturing of the product has started, I will still be liable for the charges.
6. I agree to provide Advanced Eye Care and Optical with my insurance card so they may copy it for insurance billing information. I understand if I don't provide my insurance card they may be unable to bill my insurance.
7. I consent for Advanced Eye Care and Optical to use or disclose my health information as stated in the notice of Privacy Practice that they have made available to me. I understand Advanced Eye Care and Optical has a Privacy Practices Statement consistent with U.S. law and that I may request a copy of these Privacy Practices.
8. I understand I am entitled to a copy of my contact lens prescription or glasses prescription. I authorize Advanced Eye Care and Optical to maintain these prescriptions in my medical record and understand that I may request a copy at any time.

PATIENT SIGNATURE: _____ DATE: _____

PRINT NAME: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and print your name.

RELATIONSHIP TO PATIENT: _____

NAME: _____

How did you hear about Advanced Eye Care and Optical? _____