VISION SOURCE
/IENNA EYE CARE CENTER

Office Financial Responsibility | 2017

- Payment in full is due at the time of service unless an arrangement has been made prior to your scheduled appointment. We accept cash, check, Visa, MasterCard, American Express, Discover, and HSA/FSA cards.
- All checks returned by the bank for insufficient funds will incur a $25.00 bank fee.
- Understand that should your account balance become past due and is required to be placed with a collections agency, you will be charged a collections fee of $50.00, which will be added to your balance owed.
- Be advised that the policy of this office is interest of 1.5% per month (18% ANNUAL PERCENTAGE RATE) and will be applied to all accounts over 90 days (Regardless of the insurance involvement).
- We require FULL payment for materials (glasses and contact lenses) at the time the order is placed. If you cancel that order after it has been processed you will be charged a return fee of 25% of the original order amount.
- If you decide to cancel or return glasses once they are ready and/or have been dispensed to you, a refund WILL NOT be issued. An office credit of the dollar amount will be added to your account for a future order of your choosing.
- If you require a **referral** for our medical insurance you are responsible for arriving with the referral from your Primary Care Physician (PCP) or you will be responsible for paying in-full for all services rendered at the time of the examination.
- Understand that all patients wearing contact lenses receive tests and follow-up care above and beyond a comprehensive exam. This contact lens medical evaluation is performed every 12 months whether or not new contact lenses are purchased. I under there is an additional charge for this service, called a "Contact Lens Evaluation". Most insurance companies consider contact lenses "cosmetic" and not "medically necessary;" therefore, **services related to contact lenses that are not covered will be my responsibility.** If you do not wish to incur any contact lens charges, please inform our staff **before** your examination and remove your contact lenses before your examination begins. However, if this is your choice we will not able to dispense any contact lenses to you, write a prescription for contact lenses, or be responsible for any contact lenses you might continue to wear.
- During the course of the examination, the Doctor may request further specialized tests due to medical history, family history, or to better diagnose any potential eye health problems. In many cases these tests are covered by your major medical plan. If your plan should not cover the recommended testing these charges will be your responsibility and due at the time of your appointment.
- As your eye care provider it is our responsibility to provide you and your family with the best possible eye health care. Please remember, your insurance policy is an agreement arrived at between you and your insurance company and not between your insurance company and your provider (Vienna EyeCare). Each insurance company has dozens of plans; all different. It is impossible for our staff to have complete knowledge of each one. **For our insurance patients:**
  - **If you plan to use your insurance as a form of payment** you must present a current insurance ID card to our staff no later than at the time of your appointment; if your vision plan is not listed on your major medical insurance card you must inform us of the vision plan's name so we can research and determine your coverage. ***If you have not presented your insurance information prior to the completion of your examination we will not be able to provide refunds, order cancellations or adjustment feeds AFTER services have been rendered and/or your order for glasses and/or contact lenses have been placed.*** You may be able to file for reimbursement on your own.
  - Although we pre-authorize services and material prior to your arrival, we are told by your insurance company that they will not guarantee payment of the claim until they have processed your individual claim. If your insurance company declines the claim submitted, you will be responsible for the balance owed.
  - If your deductible has not been met, your visit will not be covered by your insurance company and you will be charged today. We will file the claim with your insurance company so that the amount you paid is credited toward your deductible amount.
  - We require any and all known co-payments be paid at the time of your visit. You may have a deductible, additional co-pay or co-insurance amount, or declined services balance due after your insurance company processes your claim. This amount will be billed to you immediately upon our receipt of your explanation of benefits (EOB). The balance owed is due within 30-days of the date the bill is sent to you.
- If there are any questions concerning your bill, either today or when received by mail, it is your responsibility to ask. If we do not hear from you we will assume that you understand, and agree to pay the charges listed.
- This office maintains your patient record for a period of 6 years from last date of patient encounter, or until a minor patient reaches the age of 18. After that time, this office will destroy the records in a manner which protects patient confidentiality.
- ***Your signature indicates that you have read, understand, and agree to all of the above policies, and are responsible for payment of services rendered.***

Signature: _____ Date: _____

(Patient and/or Legal Guardian for the Account)

HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.
You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.
By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.
- The patient acknowledges that he/she has received a copy of our HIPAA practices brochure.

I agree to the terms of this consent form and agree to allow the following additional family members and/or representatives access to my protected health information:

1. _____ Relation: _____
2. _____ Relation: _____
3. _____ Relation: _____
4. _____ Relation: _____

Signature: _____ Date: _____

The Consent was signed by: _____
(Printed Name of Patient or Representative)

Relationship to Patient (if other than patient): _____

Witness: _____
(Printed Name of Practice Representative)