Please complete BOTH sides of this form. 3 signatures total.

FINANCIAL POLICIES AND ASSIGNMENT OF INSURANCE BENEFITS

We are committed to providing you with the highest quality of comprehensive eye care, and service that exceeds your expectations. We ask, in turn, that you read and understand your financial responsibility to us prior to incurring any charges.

- You are financially responsible for any charges incurred at CVEC.
- We are happy to provide an estimate of charges before you see the doctor, but the final cost may vary, depending on the complexity of the treatment.
- If we are billing an insurance company on your behalf, any estimate we provide based on information given to us by your insurance is not a guarantee. Your insurance company makes the final decision about payment when they receive a claim. We are happy to file claims with your insurance as a courtesy to you, but should insurance not pay in whole or in part for any charges submitted, or pay less than was quoted over the phone, you remain responsible for payment to CVEC.
- Medicare and Medicaid do not cover the $35 refraction fee (except for children).
- We ask for payment at the time services are provided.
- Accounts outstanding 90 days or more may be subject to an 18% annual interest charge.

- I understand and agree to the financial policies outlined above.
- I will assist CVEC in billing my insurance by keeping my information up to date.
- I hereby authorize and assign direct payment to CVEC for benefits arising out of any insurance policy, for Medicare benefits, or for payment from any party liable to me. I understand and agree that I am financially responsible for charges not covered by my insurance.
- I authorize the release of any medical information required by my insurance carrier(s). A copy of this authorization may be used in place of the original.
- For Medicare benefits, I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim.

Print Name:____________________________ Date:_____________________

➔ Signature:______________________________
(If the patient is a minor, please have the parent/legal guardian sign)

Please complete BOTH sides of this form. 3 signatures total.

Please complete BOTH sides of this form. 3 signatures total.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

- I have been offered a copy of Carbon Valley Eye Care's Notice of Privacy Practices.

➔ Signature:_____________________________

(If the patient is a minor, please have the parent/legal guardian sign)

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign.
- ☐ Communication barriers prohibited obtaining the acknowledgement.
- ☐ An emergency situation prevented us from obtaining acknowledgement.
- ☐ Other (Please Specify):

VISION PLANS AND MEDICAL INSURANCE

- Many people have both **Vision Plans** and **Medical Insurance**. It is important to understand the difference between what they cover.
    - **Vision Plans** reduce out-of-pocket costs for a routine examination of healthy eyes, contact lens exams, the measurements for eyeglasses and contact lenses, and the purchase of eyeglasses and contact lenses.
    - **Medical Insurance** covers medical eye issues. Some examples are: diabetic exams, dry eye treatment, pink eye, foreign object removal, glaucoma, cataracts, macular degeneration, and retina exams for flashes and floaters.
- In some cases, we will not know which insurance must be billed until after you see the doctor. Our office does not make these rules, insurance companies do, and we must comply as a contracted provider of services. Your copays and deductibles do not dictate which insurance must be billed.
- Your signature below indicates that you authorize Carbon Valley Eye Care to file a claim with the appropriate insurance as indicated by your exam findings.

➔ Signature:_____________________________ ____________________

(If the patient is a minor, please have the parent/legal guardian sign) Date

Please complete BOTH sides of this form. 3 signatures total.