SUMMIT EYECARE
Insurance and Financial Policy and Notice of Privacy Practices

Thank you for choosing Summit Eyecare as your provider. The following is our Financial Policy and Agreement and Notice of Privacy Practices. Please read, initial, and sign prior to being evaluated by one of our providers.

INITIAL:

_____ Your vision benefits are based upon a contract made between you and an insurance company. If you have questions regarding your vision benefits, please contact your employer or insurance company directly.

_____ We will bill your insurance as a courtesy to you. If insurance does not pay within 90 days, Summit Eyecare reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare, but it is important that you recognize that the insurance you have is a legal contract between you and your insurance company. Our office is not, and cannot be, a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

_____ In order to facilitate claims processing, you must provide all insurance policy information and changes to our office. At times you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim.

_____ You are responsible for knowing what services and materials your insurance covers and the providers and network(s) covered under your health insurance plan. Any service provided, but not covered by your insurance company, will be your responsibility to pay.

_____ Payment for optical material (i.e. glasses and contact lenses) is due in full at time of ordering.

_____ Insurance co-pays and deductibles must be paid at the time of service. After your insurance has determined benefits, any coinsurance amounts or non-covered services are the responsibility of the patient or responsible party.

HIPAA Notice of Privacy Practices

This notice describes how protected health information about you may be used or disclosed and how you can get access to this information. Please review it carefully.

On the below line please indicate any persons, facility, and or class of persons who are authorized to receive your HIPPA secured records/information:

(Names)_____

I have read and agree to the above outlined financial policy of Summit Eyecare. I agree that I am ultimately responsible for any charges incurred at Summit Eyecare. I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name/Responsible Party (Print): _____ Date: _____

Patient/Responsible Party Signature: _____ Date: _____