SUMMIT EYECARE

Insurance and Financial Policy

Thank you for choosing Summit Eyecare as your provider. We are committed to excellent patient care. The following is an explanation of our financial policy and agreement, which you must read and sign prior to any evaluation.

At Summit Eyecare, we believe that you deserve the best care. That's why we always present you with the best vision solution possible to treat your personal situation. Each year we provide outstanding vision care several hundred patients. Some of these patients have vision benefits, but some don't. If you have vision benefits, congratulations! You are very fortunate. Here are some important things that you should know:

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_____ Your vision benefits are based upon a contract made between your employer 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.

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.

Patient/Responsible Party:_____ Date:_____

<u>HIPAA Notice of Privacy Practices</u>

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.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient/Responsible Party:_____ Date:_____

Persons, facility, or class of persons who are authorized to receive the records/information:

(Name)_____