SUMMIT EYECARE
Insurance and Financial Policy and Financial Policy and Agreement

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:

_____ 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.

_____ 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.

_____ To facilitate claims processing, you must provide all insurance policy information and changes to our office. You are responsible for knowing what services and materials your insurance covers and the providers and network(s) covered under your health/vision insurance plan. At times you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim.

_____ If your insurance denies payment to your account, you will be asked to pay the balance due. If you do not pay in a timely manner, you will be responsible for all charges not paid by your insurance company in accordance with the laws. I further agree that in the event of non-payment of any amounts due under this agreement, I will pay interest thereon at the rate of 1.75% (21% annum). I also agree that in the event this agreement is assigned to an agency for collection, I promise to pay an additional collection fee of 35% of the unpaid balance due as well as all reasonable attorney fees and court costs.

_____ Cash-Pay Patients: This category includes patients with no vision and/or medical insurance and the patients who have an insurance plan with which we are not in network with. Payment for services is required upon check-out. We accept Visa, MasterCard, Discover, American Express, Care Credit, cash, checks, and money orders. We will provide you with a receipt.

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 HIPAA 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 with an opportunity to review it.

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

Patient/Responsible Party Signature: _____ Date: _____