EYECARE PROFESSIONALS & MOUNTAIN EYEWEAR

● Financial Agreement, Consent to Treat, and HIPAA

- I voluntarily give my permission to Eyecare Professionals and Mountain Eyewear to provide services to me. I understand by signing this form, I am authorizing them to treat me.
- Co-pays, co-insurance and deductibles, and charges for self pay individuals are due at the time of service and are collected at check out.
- I authorize Eyecare Professionals and Mountain Eyewear to bill my insurance company (if applicable) for services provided to me, with payment made directly to the providing doctor's office, and that such an authorization is valid until written notice is provided to cancel that authorization. I am responsible for providing accurate insurance information at the time of service. I understand that until my insurance company has paid on my claim, the final amount I may owe cannot be officially determined. **Any remaining balance is my responsibility to pay.**
- I request that payment of authorized Medicare benefits be made on my behalf to Eyecare Professionals and Mountain Eyewear for services provided to me by them. I understand that my signature requests payment be made and this form authorizes release of any medical information necessary to pay the claim. **I am responsible for the deductible, coinsurance and non-covered services such as refraction and optomap imaging.**
- I understand that if my account has a balance and receives **NO RESPONSE AFTER 90 DAYS**, I may be sent to an agency for collection. I agree to pay collection expense fees that are accrued from the collection agency. Any balance over $90 will be turned over to the agency.
- For any balance under $30 I understand that I will receive only 1 statement. If balance is not paid or office isn't notified of any issues with paying, then my account will be put on hold. No further treatment will be rendered and no items will be dispensed until balance is paid. I understand that I can contact the office of Eyecare Professionals and Mountain Eyewear to set up a payment plan or notify them of a financial hardship.
- I understand that I will be charged a 50% restocking fee for any canceled or returned order.
- Should you need to cancel or reschedule an appointment please contact our office **24 hours prior** to your scheduled appointment. Notification allows the practice to better utilize appointments for all patients in need of care. Any patient who fails to arrive at their scheduled appointment time, without contacting our office 24 hours prior to the scheduled appointment, will be charged a **$25 fee.** The fee will be charged to the individual, and will be due at the patient's next office visit. Fee will not be billed to any insurance company.
- I acknowledge that I was offered a copy of the Eyecare Professionals and Mountain Eyewear Notice of Privacy Practices in accordance of HIPAA Privacy Act.

Patient Name (Printed)_____ **Patient DOB:** ____/____/_____

Signature of Patient/Representative: _____ **Date:**____/____/____