STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Patient Name: _____ Date_____

It is the intention of INSIGHT Complete Eye Care to provide you with a clear understanding of our financial agreements and billing procedures in the hopes to prevent any misunderstanding. If you have any questions regarding these agreements, please notify the front office coordinator. Please take the time to read, initial, and sign the patient financial responsibility form.

_____If you have medical and/or vision insurance it is your responsibility to fill out the insurance details on the patient form. Please provide your insurance card to the front office coordinator to bill your insurance carrier completely and accurately. If benefits cannot be determined at the time of service, or when there is any doubt, payment in full is expected**. Please be advised that a medical insurance card does not inform our office if a separate vision plan exists.**

_____Your insurance policy is a contract between you and your insurance company. We are not a party to that contract and cannot possibly know all of the details or specific benefits allowed by your insurer. As a service to you and upon your request we can bill your insurance company if we are a participating provider. However, at the time services are rendered if no insurance is presented we will collect on doctor services and materials in full. The responsibility of filing for reimbursement will fall on the individual.

_____You are responsible for payment of any unmet deductible, co-payment, and co-insurance as determined by your contract with your insurance carrier. **We expect these payments when services are rendered.** Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim you will be responsible for your balance in full.

_____If you have a vision plan in addition to your medial insurance please be advised that during your eye health evaluation **if a medical diagnosis and/or procedure is evident, fees accessed will be billed to your medical insurance** and all deductible, co-payments, and co-insurance will apply. Your vision plan is for routine vision exams and will not reimburse if a medical diagnosis exists.

_____If you are having a contact lens exam, evaluation, and/or fitting additional fees will be assessed. **This service is only billable to vision insurance and may not be covered in full.** We do not bill any contact lens services or materials to medical insurance. If contact lenses are deemed medically necessary due to cornea transplant, kerataconus, ectasia, etc, we will bill your vision insurance. Billing medical insurance for these diagnoses will be reviewed on a case by case basis and assignment will not be accepted.

_____There are normal and expected times that we will need to re-bill your insurance company. However, if there becomes a time when the costs of completing your billing are over and above the usual and customary time spent to process and follow-up on a claim, we will contact you. If at this time payment has not been received by your insurance carrier payment will be expected in full by you and you may pursue collecting personally. If you would like us to continue to pursue billing your insurance company, you will be charged $20.00 for the additional time spent on the claim as well as payment in full. The $20.00 charge will be for each consecutive sixty (60) days that we continue to work on the bill. If and when payment is received from your insurance carrier you will be reimbursed.

_____Once payment is received on your behalf from your insurance carrier any balances due for unmet deductible, co-payments, and co-insurance that have not already been collected will be billed to you. After thirty (30) days of the first bill, a 1% annual or minimum of $2.50 per month finance charge will begin to apply on your account. Any bill over ninety (90) days past due will be subject to collection procedures. Collection procedures include but are not limited to a final collection notice and an attempt to reach you by telephone. If you fail to make payment arrangements your account will be turned over to a professional collection agency.

_____Upon receipt of payment from your insurance provider, you may end up with a credit balance. Any overpayment will remain on your account as a credit to be used towards future services or material purchases. If you would like to be issued
a refund, please let us know and we will issue a check within thirty (30) days of your verbal or written request.

_____There will be a $25.00 service charge for any returned check. After receiving a returned check, Insight Complete Eye
Care will no longer accept a check on your account. Payments will have to be made using cash or credit card.

I have read the above policy regarding my financial responsibility to INSIGHT, Complete Eye Care for services performed to myself or the above named patient. I authorize my insurer to pay any benefits directly to INSIGHT, Complete Eye Care. I agree to pay the full and entire amount of all bills incurred by the above named patient, as well as any amount due after my insurance carrier has made a payment.

Patient Signature

Patient Printed Name

Guarantor/Responsible Party Signature
Printed Name

Guarantor/Responsible Party

_____
Date

_____

_____

_____

_____

_____

INSIGHT
COMPLETE EYE CARE

FORMER PATIENT FORM

Personal Information

Last Name:_____ First Name: _____ Initial:_____

SSN: _____ Marital Status:_____

Address:_____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Work Phone: _____ Home Phone: _____

Cell Phone: _____ Email Address: _____

Text Opt In: Yes / No **Text Opt In: Yes / No**

Insurance Information

(Please present insurance cards with completed forms)

Medical Coverage

Name of Insured (if other than patient): _____

SSN: _____

D.O.B: _____

Insurance Provider: _____

Group #: _____ Member #: _____

Vision Coverage

Name of Insured (if other than patient): _____

SSN: _____

D.O.B: _____

Insurance Provider: _____

Group #: _____ Member #: _____

Medical Information Privacy Notice Summary

Dr. Ivan Bank and Dr. Tracy Stringfield

This notice is required by law to inform you of the ways in which we may use your confidential protect health information.

1). For treatment- We may release your medical information to other physicians fro consultations, referrals, and coordination of your health care.

2). For payment-We may release your medical information to an insurance company or third party about your treatment so we may be reimbursed for your care or to obtain prior approval or to determine of your insurance company will cover the treatment.

3). Appointment reminders-We may use and disclose medical information to contact you as a reminder that you have an appointment for medical or to change an existing appointment.

4). Individuals involved in your care or payment for your care-We may release medical information about you to a friend or family member who is involved in your medical care or payment of your medical care.

5). Workers compensation-We may release your medical information about you for workers compensation or similar programs

You have the right to inspect and copy your medical information. You must submit your request in writing to the privacy officer. We may charge a fee for the cost for copying mailing or other supplies associated with your request. You have the right to request that we amend your medical information if you feel the information is incorrect or incomplete. The request must be in writing and must include the reason you wish to amend your information.

This is a summary of part of the Privacy Practices for Drs. Bank and Stringfield. If you would like the complete privacy notice form, please notify the receptionist or one of our office staff.

_____ _____

Signature of Patient Printed Name and Date