FINANCIAL POLICY

Patient Name (print): _____ DOB: _____

Our provision of care to you will result in a bill for our services. The following is a statement of our Financial Policy, which we require you read and sign prior to your treatment. In addition, all patients must provide basic registration and insurance information before seeing the physician.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. UNLESS WE ARE BILLING YOUR INSURANCE FOR YOU, IN WHICH CASE, ANY APPLICABLE CO-PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT VISA, MASTERCARD, DISCOVERCARD, OR CARE CREDIT.

INSURANCE

A copy of your medical insurance card is required at the time of each visit so we can set up the correct billing information. You are responsible for any amounts not covered by your insurance, including co-payments, deductibles, co-insurance, and non-covered charges. Your insurance policy is a contract between you and your insurance company and we are not a party to that contract. If you do not inform us of any special requirements or guidelines in your policy, such as second opinions, pre-authorizations, preferred providers and covered and non-covered services, and we subsequently perform or order items or services that are not covered, we will bill you directly for those charges. If your insurance company has not paid your account within 45 days, the account automatically becomes your responsibility and will become due immediately. Please be aware that some of the items or services provided may not be covered or may not be approved for payment under your policy, but have been determined to be medically necessary by your physician.

REFERRALS

I, the undersigned, understand that my insurance carrier may require a referral/authorization before approving payment for services received. If the required referral and/or authorization is not received prior to my scheduled appointment, I understand that I will be responsible for the total amount of the bill.

RESPONSIBILITY

If you are 18 years old or older, you are legally responsible for your own account. If under 18 years of age, your parent(s) or legal guardian is responsible for payment.

I have read the Financial Policy and understand and agree to its terms.

X _____ Date: _____

Signature of patient or responsible party

MEDICARE – ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare benefits be made on my behalf to PNW EYE PLLC, for any services furnished to me by any physician or other provider employed by PNW EYE. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents. Any information needed to determine these benefits or the benefits payable for related services. I understand my signature requires that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. I understand that PNW EYE accepts the charge determination of the Medicare carrier as the full charge for all authorized Medicare benefits, and I am responsible only for the deductible, coinsurance, and non-covered services. I understand that coinsurance and deductible are based upon the charge determination of the Medicare Carrier. I have read the assignment of benefits and agree to its terms.

X _____ Date: _____

Signature of patient or responsible party