AUTHORIZATION AND RELEASE

I authorize the doctor to release any information, including the diagnosis and the records of any treatment or examination rendered during the period of such care, to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

LATE CHARGES

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% (18.00% APR) or at least a minimum service charge of $2.50 on the unpaid balance will be assessed each month. I realize that failure to keep this account current may result in this office being unable to provide additional services except for emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay for collection costs and reasonable attorney fees occurred in attempting to collect on this amount or any future outstanding account balances.

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Signature of patient (parent or guardian, if minor) Date

TRICARE/CHAMPUS PATIENTS

The official policy of TRICARE/Champus states that certain services may not be a covered benefit. Only examinations for eyeglasses and eye disease services are covered. We are required to collect usual and customary fees for all non-covered services. In addition, any **medical** or **vision** insurance is primary (must be used first) to TRICARE. The following services may not be a covered benefit through TRICARE/Champus:

1. Contact lens evaluations
2. Visual field evaluations
3. Retinal photography

By signing this form below, you agree to be financially responsible for any non-covered fees through TRICARE/Champus.

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Signature of patient (parent or guardian, if minor) Date

MEDICARE PATIENTS

Medicare will only pay for services that it determines to be "Reasonable and Necessary" under Section 1862(A)(I) of the Medicare Law. If Medicare determines that a particular service, although it would be otherwise covered, is not "Reasonable and Necessary" under Medicare program standards, Medicare will deny payment for that service. In other words, **Medicare will only cover medical visits, routine eye exams are not covered**. As refractions are not considered medical, I understand that I am responsible for paying the refraction fee at the time of service. In addition, if Medicare denies payment for any particular service, I agree to be personally responsible for payment.

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Signature of patient (parent or guardian, if minor) Date

FINANCIAL POLICIES

We are dedicated in providing the best possible care and service to you and believe that your understanding of your financial responsibilities is an important element of your relationship with our practice. In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy.

Your insurance policy is a contract between you and your carrier. **The doctor is NOT involved**. All health plans are not the same and do not cover the same services at the same payment schedule. Due to the large numbers of plans that we deal with, we cannot assure you that any specific amount of any charge will be covered. **Your involvement in knowing what your insurance covers is important and we encourage you to become familiar with your plan**. This information is best obtained by calling your insurance company.

If your insurance requires a referral, it is your responsibility to obtain the referral. Please check with your carrier to see if your visit to a specialist requires a referral. If your policy stipulates that you need a referral and you do not have one, we will give you the option of rescheduling your visit or not using your insurance. Again, this is your contract with the insurer and we have little ability to impact it.

We file insurance claims for all patients with whom we have a participating agreement. We would like to participate with and accept assignment on ALL insurances, but we cannot due to limitations BY THE INSURANCE COMPANIES. We have asked to be included in many of the networks, but if we do not participate, it is usually because of circumstances beyond our control. This is always a concern for us and we work to increase our options and serve on all panels that would like to have our care. **Please be sure that your insurance will permit you to see us**. This is especially true for PPO and HMO networks.

Deductibles, co-payments, and "non-covered" amounts are the responsibility of the patient. They are due at the time of service. It is an insurance violation for us to waive any co-payments or deductibles.

Payment is due in full when services are rendered, unless arrangements are made in advance. For your convenience, we accept most credit cards.

Continue on reverse