Patients Name_____

ACADMEMY VISION SCIENCE CLINIC
CLINICAL FINANCIAL POLICY AND AGREEMENT

Thank you for choosing us as your health care provider. We are committed to provide the highest quality care and treatment for you. Full payment for services and/or co-insurance payment are due at the time of service. We accept cash, checks, VISA/MASTERCARD or DISCOVER cards, for large purchase amounts and with approved credit, Pulse Care may be another payment option. We require you to read and sign this Financial Policy Statement, HIPPAA Federal Notice of Privacy Practices, Patient Demographic and History Forms, and any Insurance forms prior to treatment. To save time, our web site www.academyvision.com has these forms also.

Regarding Privacy and Medical Records Releases

Because new Federal HIPAA and Insurance regulations govern how patient confidentiality is protected, we may require specific written and signed consents and/or authorizations from you before we can communicate any patient information to third parties. After we receive a written request from you, all information releases will be in accordance with HIPAA Notice of Privacy Practices and Regulations.

Your Responsibility

Your signature below declares that you are responsible for and authorize treatment of the person named herein. You agree to pay all fees and charges for such treatment. We must emphasize that our primary mission is to deliver medical care – not financial advice. Our relationship therefore is solely with you, not your insurance company or any third party payer. We will not be accountable for interpreting any third party payer's payment policies. The person being seen by the doctor (the patient), or, if the patient is a minor, then the adult person bringing the child, is responsible for full payment. For unaccompanied minors, non-emergency treatment cannot be delivered unless written consent for treatment has been given and charges have been pre authorized to a VISA/MC or DISCOVER card, or payment of cash or check at the time service is made.

Collections and Billing

You will receive a monthly statement. Finance charges accrue monthly at a 1.75% times the outstanding balance. A $25.00 rebilling fee will be added to any account if it is necessary to re-submit a bill to your insurance company; this fee simply covers our cost (postage, employee time, etc.) incurred in billing.

In order for us to provide the highest quality of care and because some patients unfortunately have not been responsible about paying their fees, if an account has been billed and remains unpaid for over 90 days without payment, the account will be turned over to collections. All collection fees, attorney's fees, cost of service, and court costs will also assess. Any overdue account that is turned over to collections will be charged an additional 33.3% to cover collections costs.

We will not intentionally turn any account over to collections if the patient is cooperation and making a reasonable effort to keep their account current.

If you think there has been an error on you account you must notify us in writing within 30 days of its posting and we will make every effort to correct the situation. Returned check fees are $35.00

Missed Appointments

Please help us to serve you by keeping scheduled appointments. If you will be unable to keep your scheduled appointment, you must cancel it on the preceding day. If an appointment is missed and not canceled by the preceding day, we will charge $30.00 per 30-minute appointment.

Regarding Insurance

We may accept assignment of insurance benefits if we are a participating provider. Any remaining balance is your responsibility. In order for us to bill your insurance company, you must give us current and correct insurance information. Your insurance policy is a contract between you and your insurance company only. We are not party to that contract. Please be aware that some, and perhaps all, of the services we provide may be non-covered services and may not be considered reasonable and/or necessary under your health insurance policy even though we do. If we are a participation provider, all co-pays are due prior to treatment. If your insurance company does not pay all amounts due, you are still obligated and responsible to pay full amount charged. Since there are a multitude

Of policies, you are solely responsible for knowing and determining your insurance company eligibility criteria, coverage amounts and deductibles, obtaining prior authorizations and referrals, and compelling your insurance company to pay. Since our practice is committed to and is focused on providing the best optometric treatment for our patients, we cannot represent or act as agents fro your insurance company or interpret their policies. We will bill one insurance company one time as a courtesy, thereafter additional fee will apply if rebilling is required or your insurance company requires additional information. Follow up of your insurance claim is your responsibility. You are responsible for payment regardless of any insurance company's arbitrary determination of eligibility, unusual and customary rates, or reasonableness and necessity.

Consent

I have read the terms and conditions set forth above. My signing below, I accept and agree to these terms and conditions. I further agree to pay all fees and charges for treatment and materials the day services are rendered. I certify that my personal history and personal information are correct. I acknowledge that I read and received a copy of Academy Vision Science Clinic's HIPAA Notice of Privacy Practices Form.

Signature_____ Date_____