Eye Clinic and Contact Lens Center of Utah Valley, P.C. and CottonTree Optical (Eye Clinic)

FINANCIAL POLICY, AGREEMENT, and PATIENT CONSENT FORM

Patient Name:____

We are committed to provide you with the best possible eye care. Your understanding of our Financial Policy is important to our professional relationship. Please ask a staff member if you have any questions regarding our fees, financial policy, or your responsibility.

Our office is filing insurance claims with an increasing number of insurance companies; therefore it is impossible for us to keep a record of your personal insurance coverage. PLEASE READ YOUR INSURANCE CONTRACT TO UNDERSTAND THE BENEFITS AVAILABLE TO YOU. As a service to you we will file insurance claims for services we provide , but it is your responsibility to make sure your insurance company has paid these claims.
REFERRAL FORMS: Many insurance companies require patients to bring a referral form from their Primary Care Physician at the time of our service. Any charges not paid by your insurance company because we had no referral to submit, will be YOUR responsibility. Always keep a copy of all referral forms.
INSURANCE CARD: If you do not have your insurance card or proof of insurance, YOU are expected to pay in-full for your visit at the time of services.
CO-PAYMENTS: You are required to make this payment at the time of service.
PRE-AUTHORIZATION Many insurance companies are requiring pre-authorization for special procedures. On your request, we will pre-authorize special procedure with your insurance company. You must call them to confirm your benefits as they do not tell us what benefits are available when we pre-authorize. PRE-AUTHORIZATION IS NOT A GUARANTEE OF BENEFITS.

ASSIGNMENT OF BENEFITS AND FINANCE CHARGES: I understand and accept FULL financial responsibility for services/products provided to me and/or my dependants by the Eye Clinic and Contact Lens Center of Utah Valley, P.C. and CottonTree Optical (Eye Clinic). In the event that payment in full for charges incurred is not made I agree to pay all costs of collections including a 50% collections fee, attorney fees, court costs and interest at the rate of 1.5% per month (18% per year). I hereby assign my insurance benefits to be paid directly to the Eye Clinic. Payment of all deductibles are due at the time of services. I understand that I am financially responsible for all non-insurance-covered services/products provided by the Eye Clinic. I also know that it is my responsibility to know and understand my insurance benefits and it is not the responsibility of the Eye Clinic to interpret those benefits or to collect them.

I, give my authorization to the Eye Clinic and Contact Lens Center of Utah Valley, P.C. to release any information including my medical and financial records to my insurance company. This information may be transmitted by any means of conveyance ie. mail, FAX e-mail or other method of electronic transfer of information.

PLEASE READ CAREFULLY: I understand that in order to comply with HIPAA's privacy rule, the Eye Clinic and Contact Lens Center of Utah Valley, P.C. has made available its notice of Privacy Practices document. I have been given the opportunity to read this document and can receive a copy of my own to take with me. I have been given the opportunity to ask any questions regarding the privacy policies of this office.

I certify that all information provided by me is correct.

Signature: (parent or guardian if a minor)____________________________________

Date:________________________

Revised March 2009