SPECIALIZED EYE CARE

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for choosing Specialized Eye Care ("SPEC") for your eye care. Please read and sign this agreement to acknowledge our financial policies.

Patient Financial Responsibilities

- We are pleased to assist you by billing our contracted insurers. You are responsible for providing us the most correct and updated insurance information in a timely manner.
- We will assist you, but ultimately, you are responsible for determining if we accept your insurance provider and obtaining any necessary physician referrals or authorizations prior to treatment.
- You are responsible for any charges that your insurance does not pay and for any services and products not covered by insurance. This includes any charges applied to your insurance deducible. (Your deducible is the amount for which you are personally responsible before your insurance covers your medical expenses. For example, if your deductible is $250 and has not been met, and your medical charge is $400, then you will owe $250.) We are happy to check the amount of your deductible, and how much of the deductible has been met. If you would like us to do this for you, please ask our front desk.
- Payments for co-payments, co-insurance, deductibles and payments for services not covered by insurance are due at the time of service.
- We accept cash, check, and most credit cards. There is a $25.00 returned check fee.

Contact Lenses Policies

- Contact lenses are generally not covered by medical insurance. If you have a vision plan that covers contact lenses, you can submit a receipt for your charges, and may be reimbursed. We are an out-of-network provider with vision plans, as we cannot accept vision plans. There will be separate charge for the professional contact lens fitting service. This charge ranges between $40-100.
- Some medical insurance plans will reimburse for medically necessary contact lenses. We have forms to assist you to request reimbursement for medically necessary contact lenses. (The cost of the professional fitting service for medically necessary contact lenses may be covered by your medical insurance.)
- Upon receipt of contact lenses, you are responsible for full cost of the contact lenses.
- **Signature of this form serves as an Advanced Beneficiary Notice (ABN)**
  If your insurance company reimburses you for a portion of your lenses, you are still responsible for the full cost of the lenses. For example, if you are reimbursed $100 for your contact lenses, and cost from SPEC is $250, we cannot refund the remaining $150.

Patient Authorizations

- I authorize SPEC to release and send any necessary information, including medical information regarding my case to the insurance company and any other consulting and/or referring physicians.
- I consent to the use and disclosure of PHI (Private Health Information) for any treatment, payment, and health care operations. I authorize SPEC to access my medication history through e-prescribing and to use e-prescribing as a form of generating my prescriptions or renewing my medications.

I have read, understand and agree to this Patient Financial Responsibility Agreement.

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Printed Name of Patient or Representative If Representative, Relationship to Patient

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Signature of Patient or Representative Date