

FINANCIAL POLICY

We hope you understand that our financial policies are established to assure the financial resources needed to maintain this office for all our patients.

PAYMENT

Charges for services are due and payable at the time of service. We accept cash, checks, Visa, MasterCard and Discover. Finance charges will be added to any unpaid balance over 60 days.

HEALTH INSURANCE

Your insurance policy is an agreement between you and your insurance company. Our relationship is with you and not with your insurance company. Therefore, all charges are ultimately your responsibility, regardless of your insurance status.

- ◆ If we participate with your insurance company, we will file the claim for you.
- ◆ If we do not participate with your insurance company, payment is expected at time of service.

Co-payments or other patient due amounts are expected at the time of service. Accounts 30 days past due are subject to collection proceedings unless prior payment arrangements have been made with our business office.

LIFETIME INSURANCE AUTHORIZATION

I authorize Snowy Range Vision Center to release to my insurance company any information needed to determine benefits payable for related services. I request that payment of Medicare, Medigap or other insurance benefits be made on my behalf to Snowy Range Vision Center for any services furnished to me by Snowy Range Vision Center optometrists or suppliers. I understand that I am responsible for all charges regardless of insurance coverage.

I acknowledge that I was shown and offered a copy of Snowy Range Vision Center's
Notice of Privacy Practices.

Print Patient(s) Name(s) _____

Responsible Party Print Name _____

Responsible Party Signature _____ Date _____

If you would like our office to leave messages regarding your health or billing information please mark the following:

___ message on my home phone ___ message on my work phone ___ message on my cell phone

Please list party(s) that we can discuss billing and/or health information (only listed individuals can receive information including parents)

Name _____ Phone _____ Relationship _____ Emergency Contact __Y__N

Name _____ Phone _____ Relationship _____ Emergency Contact __Y__N

Name _____ Phone _____ Relationship _____ Emergency Contact __Y__N

Name _____ Phone _____ Relationship _____ Emergency Contact __Y__N

Name _____ Phone _____ Relationship _____ Emergency Contact __Y__N

PLEASE RETURN THIS FORM TO A RECEPTIONIST