FINANCIAL POLICY

As physicians, we are committed to giving you the best possible medical care. To achieve this goal, we need your assistance and understanding of our payment policy. We must emphasize that as your physicians, our primary relationship and concern is with you and your health, not with your insurance company.

Managed Care Plans: As providers we ask that the co-pay and deductibles (if applicable) be paid in full at the time of your visit. We accept assignment for services covered and bill the insurance. Any balance outstanding, following payment from insurance, will be billed to you.

Medicare: We are participating Medicare providers and will file your medical claims to Medicare for you. Services routinely not covered by Medicare (i.e. Refraction/Routine Exams) will require payment at the time of service. We also request payment for the 20% co-insurance of the allowable Medicare charges and any deductible (if applicable) that has not been met at the time of your visit.

Financial Agreement: We will be glad to discuss your proposed treatment and the cost of those services if you have questions about your insurance coverage of a medical service. HOWEVER, please be aware that your insurance is a contract between you, your employer (if applicable) and the insurance company. We are not a party to your contract. Unfortunately, not all services are covered benefits in all contracts.

All charges for services are your responsibility at the time of service. Collection action may be taken for any balance on accounts that are past due. We realize that emergencies do arise and may affect timely payment on your account. If such extreme cases do occur, please contact our office promptly for assistance in management of your account.

If you have any questions regarding the above, any uncertainty regarding insurance coverage or request for payment please do not hesitate to ask. We are here to assist you.

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding health information. I understand that this information can and will be used to :

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practice containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practice from time to time to obtain a current copy of the Notice of Private Practice.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.
I understand and agree to the financial and HIPAA policies for 1960 Eye Surgeons, PA.

_____ _____

Patient/Legal Guardian Signature Date

_____ _____

Witness Date