Today's Date: _____

Name: _____

CHIASSON EYE CARE CENTER

Financial Policy

Thank you for choosing Chiasson Eyecare Center to serve you and your family's eye care needs. We look forward to establishing a lasting relationship as your eye care provider. As part of this relationship we wish to establish our expectations of your responsibility as outlined in our policy. YOUR INSURANCE is a contract between you and your insurance company. We file claims and provide information to help you in filing claims, but you are primarily responsible for any changes that you have incurred as patients with Chiasson Eyecare Center.

Please review and sign the following financial policy prior to seeing the doctor:

1. **Payment** is expected at the time of your visit. We accept cash, check, Visa, MasterCard, and Discover. Payment will include any unmet deductible, co-insurance, co-payments, non-covered charges, and existing balances. If your insurance is Medicare only, you will be responsible for 20% of allowed amount at time of your visit.
2. Patient must complete insurance information and provide all insurance cards at the time of visit. It is your responsibility to know your current insurance. If the insurance company has not paid a claim on your behalf within 90 days, you will be responsible for payment.
3. I understand that I am financially responsible to Chiasson Eyecare Center for all charges for all services rendered to my family or myself. I hereby assign payment of any insurance benefits that are filed by Chiasson Eyecare Center for services for my family or myself. If you have financial hardship or if you are unable to pay your bill in entirety, please contact our billing office to discuss payment options. If your account becomes delinquent and have not made an effort of payment your account will be turned over to a collections agency. I understand the collection agency fees will be the responsibility of myself.

I have read the financial policy above and agree to terms:

_____ _____

Patient/Responsible Party Signature Date

About Your Insurance

There are two types of "insurance" you may have which will help pay for your eye care services and products.

Our Practice accepts both:

1. Vision care plans (such as VSP & Eyemed)

2. Medical Insurance (such as Blue Cross, Medicare, United Healthcare)

-Vision care plans cover only routine vision exams along with eyeglasses and contacts lenses. Vision plans only cover a basic screening for eye disease. They do not cover diagnosis, management, or treatment of eye disease.

-Medical insurance must be used if you have any eye health problems or systemic health problems that has ocular complications. Your doctor will determine if these condition apply to you, but some are determined by your case history.

-If you have both types of plans it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expenses.

-We will bill your insurance plan for services if we are participating provider for that plan. If some fees are not paid by your plan, we will bill you for any unpaid deductibles, co-pays, or non-covered services as allowed by the insurance contract.

I have read and agree with these policies:

_____ _____

Patient/Guardian Signature Date

Today's Date: _____

CHIASSON EYE CARE CENTER

Patient Information

Name: (Last) _____ (First) _____ (MI) _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____/_____/_____ Home Phone: (_____)_____

SS #: _____-_____-_____ Cell Phone: (_____)_____

Gender: Male Female Choose not to disclose Work Phone: (_____)_____

Race/Ethnicity: _____ Employer: _____

Email Address: _____

Emergency Contact: _____ Phone #: (_____)_____

Responsible Party Information

Person responsible for patient account: _____ Relationship to patient: _____

Date of Birth: _____/_____/_____ Phone #: (_____)_____

Health/Medical Insurance Information

Primary Insurance: _____ Policyholder Name: _____

Date of Birth: _____/_____/_____ Relationship to patient: _____

SS #: _____-_____-_____ Member ID #: _____

Additional Information

Primary Care Physician: _____ Referred by PCP? Yes or No

Preferred Pharmacy: _____ Location: _____

No Show Policy

When we schedule your appointment, we do our best to see you at that scheduled time. If you do not show up for your appointment or call to reschedule/cancel ahead, then it is considered a "No Show." If this happens three times, we reserve the right to ask you to find a new optometrist. We also reserve the right to reschedule your appointment if you are more than 15 minutes late. This policy is in place to not only take in to account our clinic's time, but the time of other patients at well.

Signature_____ Printed Name _____

HIPAA Privacy Policy

I have had the opportunity to read and understand the HIPAA Privacy Policy of this clinic.

_____ _____ _____

Signature of Patient/Guardian Print Name Date