Mercy Eye Care

PAYMENT IS REQUIRED AT TIME OF SERVICE. IF YOU DO NOT HAVE YOUR COPAY PLEASE SEE THE RECEPTIONIST TO RESCHEDULE YOUR APPOINTMENT.

(Please initial each section and sign at the bottom)

_____I understand the charges listed below and I understand that payment is required on date of service. I understand that to process an order for glasses or contact lenses the patient balance must be paid in full.

EXAM FEES

The fee for a refraction (determining your prescription for corrective eyewear) is separate from the fee for the routine eye health exam. The refraction charge is $30 and is not covered by some insurance plans.

_____I have been informed and I understand the charges for the refraction and that I am responsible for this fee. The fee for a contact lens evaluation is separate from the fee for the routine eye health exam. This fee ranges from $30-$150 depending on the type of lenses you require and whether you are an existing contact lens patient. Your insurance plan may or may not cover this fee.

_____I have been informed of the contact lens evaluation fee policy and I understand that I am responsible for this fee.

RELEASE OF INFORMATION

_____I authorize Mercy Eye Care to release examination and/or glasses/contact lens information to my insurance carrier, vision plan or party that is or may be liable for my charges. Only information necessary to determine benefit entitlements and to process claims shall be released. This authorization is valid only for the period necessary to process claims pertaining to the patient.

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

_____I hereby authorize my vision or medical plan benefits to be paid directly to Mercy Eye Care. I understand that I am financially responsible for non-covered product and services as well as deductibles, coinsurance, or amounts in excess of insurance benefits. I understand if insurance does not pay for any reason including not having needed referral, incorrect insurance plan indicated, or products/services are not covered, etc. I am responsible for payment.

PATIENT'S RIGHTS AND RESPONSIBILITIES

_____I have received a copy of and understand my rights and responsibilities under the Health Insurance Portability and Accountability Act (HIPAA).

_____I understand that it is my responsibility to pick up all products purchased including glasses and contact lenses. I understand if there is an outstanding balance on a product purchased that has not been picked up the balance can still be sent to collections.

_____ _____

Patient Name Patient DOB Date

_____ _____

Signature of Patient or Guarantor Date