EYE CARE CENTER OF NORTHERN COLORADO, P.C. POLICIES FORM

We find that our clients appreciate knowing in advance what is expected of them financially and what terms and conditions are available. Please read the following information carefully. "I" refers to the patient, the guarantor for a patient under 18 years of age, or a legally authorized signer for a patient who is handicapped. If you should have any questions, please direct them to our Business Office. The Eye Care Center of Northern Colorado, P.C., will be known as ECCNC in this document.

REFERRALS

I understand that it is my responsibility to obtain a referral through my Primary Care Physician's office if one is required by my insurance carrier(s). Failure to do this will result in the charges being billed directly to me.

ASSIGNMENT OF MEDICAL BENEFITS

I authorize my insurance carrier(s) to assign all surgical and or medical benefits, if applicable, to the ECCNC. I also authorize release of medical information necessary to process all medical insurance claims.

PATIENT PAYMENT

I understand that all fees must be paid at the time the service is provided. Payment may be made by cash, check, or accepted credit card (VISA, MasterCard, or Discover). Any other payment arrangement must be authorized in advance by the ECCNC Business Office.

INSURANCE

I understand that my current insurance card(s) and an identity are to be presented at each visit. Failure to do this will result in my being billed directly. I also understand that co-payments are to be paid at the time of service in the form of cash, check, or accepted credit card. I understand that billing my insurance is done as a courtesy and that the ECCNC will not be responsible for collecting overdue insurance claims or negotiating settlement on disputed claims. My insurance company is required by the Colorado Insurance Commissioner to process, pay, or reject all insurance claims within 30 days. The ECCNC will file based on the information I provide at time of service. If the ECCNC is contracted with my insurance carrier(s), I understand that they will accept the contracted rate for the charges billed. I will be responsible for any balance my insurance deems patient responsibility/non-payable/non-covered, and I will make payment in full upon receipt of statement or by payment arrangement authorized by the ECCNC Business Office in advance. I understand that if I fail to pay my account in full within 60 days of becoming patient responsibility, a $10 Rebilling Fee will be added to my account and the account will be subject to collections. I also understand that if I make payment by check and it is returned for Non-Sufficient Funds, a $25 Returned Check Fee will be added to my account and I will have to make future payments by cash, money order, or accepted credit card.

VSP (GLASSES) INSURANCE

I understand that VSP will be billed on my behalf for appointments scheduled as "Well-Eye (Routine) Exams" and for prescription glasses or contact lens.

OPTICAL

I understand that all optical goods, contacts, or medical devices must be paid for in full (or according to my insurance) at the time they are ordered as they are custom-fitted for me individually.

COLLECTIONS

I understand that if I fail to make payment on my account, the account will be turned over to an outside collection agency. I also understand that a $50 Collection Fee will be added to my account and my family and I will be discharged from being seen by any doctor at the ECCNC. I acknowledge that I will be responsible for all legal costs including collection fees and attorney fees if I fail to pay my account.

EMERGENCY VISIT

I understand that an emergency visit is one in which I request to be seen by a physician within 24 hours or the triage staff deems my symptoms necessitate an examination within 24 hours. I also understand that I will be responsible for a $70 Emergency Fee charged for the visit in addition to the examination charge and any other applicable charges.

MISSED APPOINTMENTS / CANCELLATIONS

I understand that I am responsible to show up on time for my scheduled appointment. If I am late, I acknowledge that if possible I will be given the option to be worked into the schedule with an undetermined wait time or have my appointment rescheduled. I understand that the first time I miss or cancel my appointment within 24 hours I will receive a reminder letter. The second time I miss or cancel my appointment, I will be charged a $30 Cancellation Fee. I understand that if subsequent appointments are missed or cancelled with short notice, I may be discharged from the practice. I also understand that multiple patients scheduling appointments together must cancel no later than 48 hours prior to the scheduled appointment or each person will be charged a $30 Cancellation Fee.

NOTICE OF PRIVACY

The ECCNC follows HIPAA guidelines. A copy of our HIPAA policy is available upon request.

__________ INITIALS   __________ DATE