EYECARE SPECIALTIES
OF NORTHWEST COLORADO

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Welcome To Our Practice

PAYMENT IS DUE AT THE TIME OF SERVICE. We will provide you with all necessary information so you may file a claim with your insurance carrier for reimbursement. Arrangements must be made with our office prior to service if an account balance is anticipated. If I do not pay the entire balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $3.00 for a balance under $200.00), which is an annual percentage rate of 18%, applied to the last month's balance. In the case of default of payment, I agree to pay any legal interest on the balance due, together with reasonable attorney fees incurred to effect collection of this account or future outstanding accounts. I also agree that the county where services are rendered will be the correct county of venue in case of court proceedings to collect payment. A NSF Check fee in the amount of $20.00 will be charged for all returned checks.

PRIVATE INSURANCE: All private health insurance plans represent a contract between yourself and the insurance company. These contracts are not between the physician and the insurance company. We will do our best to help you obtain benefits, but we cannot be responsible if your carrier does not pay. We require payment at the time of service on any insurance we do not accept.

INSURANCE CONTRACTS: If we have a "Participating Contract" with your insurance carrier, we will accept assignment on all covered services and bill your carrier for you. You are responsible for the co-pay, coinsurance, and deductible and for all non-covered services at the time of service.

MEDICARE: We accept Medicare Assignment. This means that we accept what Medicare allows for covered services. Medicare will usually pay 80% of the allowed charges, and the patient is responsible for the remaining 20% plus the annual deductible. Medicare will not pay for medically unnecessary services, such as routine examinations and refractions, (which determines the prescription for glasses). You are responsible for the co-pay, deductible and for all non-covered services at the time of service.

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION: I authorize the release of medical information necessary to process my claim. I authorize the payment of medical benefits to Eyecare Specialties for services rendered. **I have read and understand the policies described above. I acknowledge that I am responsible to pay all charges for treatment administered by Eyecare Specialties as outlined above.**

Signature of Responsible Party: _____ Date: _____

IF PATIENT IS A MINOR, PLEASE PROVIDE THE FOLLOWING INFORMATION:

If patient is child: _____ _____
Mother Father

Responsible Party: _____ Relationship: _____

Address: _____ Social Security #: _____

Home Phone: _____ Work Phone: _____ Employer: _____

CONSENT FOR TREATMENT OF A MINOR: I hereby give consent for Eyecare Specialties to provide Optometric services to the minor patient.

Signature of Responsible Party: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I was given the opportunity to receive a copy of this Notice of Privacy Practices.

Patient Name_____ Signature_____

I authorize Eyecare Specialties to disclose my protected health information (PHI) to:

Name_____ Relationship to Patient_____

Authorization Expiration Date_____

PHI to be disclosed: ☐ Entire Record ☐ Medical Records Only ☐ Financial Records Only

~ THANK YOU ~