CASCADE EYE CENTER

PATIENT FINANCIAL AGREEMENT AND OFFICE POLICIES

Thank you for choosing Cascade Eye Center.
We are committed to providing you with the best eye care possible.
In order to accomplish this, we need your assistance in understanding our practice policies.

1. **PAYMENTS:** Full payment is due for all copays, deductibles and out of pocket expenses at the time of service unless other arrangements are made prior to seeing the doctor.

- **CONTACT LENS** services may not be included in your vision benefit and additional fees may apply (see our Contact Lens Policy).
- **REFRACTION FEE** is the portion of your exam that determines your prescription and is necessary for certain medical diagnosis. Most vision plans cover this fee, but certain medical insurances, such as MEDICARE do not. **The out of pocket cost is $40.00**.
- All contacts and/or glasses require 50% down payment to order and the remaining balance at pick up. (see our optical department for discounts and warranties).
- For your convenience, our office accepts cash, check, Care Credit, and all major credit cards.
- **RETURNED CHECKS** are subject to a $35.00 service charge.
- **CANCELLATIONS AND LATE ARRIVALS:** If you are unable to make your scheduled appointment, please contact our office to cancel or reschedule. **Failure to do so will result in a $25.00 no show fee.** If you are more than 10 minutes late to your scheduled appointment, we will need to reschedule you to a later date.

2. **INSURANCE AND PATIENT RESPONSIBILITY:** Our clinic offers both routine as well as medical services. It is your responsibility to provide complete and up to date insurance information. **Your insurance policy is a contract between you and your insurance company; we are not a party to that contract**. **Verification of eligibility is done as a courtesy only and is not a guarantee of payment. If you have a managed care plan that requires a referral, it is your responsibility to obtain this prior to your scheduled appointment.** Check with your insurance plan administrator if you have any questions regarding your coverage and/or benefits. **In order to bill your insurance and to meet filing guidelines we do ask for a copy of your insurance card(s), as well as your photo ID.**
3. **SELF-PAY PATIENTS:** All charges are due at the time of service.
4. **RESPONSIBILITY FOR PAYMENT:** I understand that I, personally, am financially responsible to Cascade Eye Center for services not covered by the assignment of insurance benefits and all non-covered charges.
5. **AUTHORIZATION AND ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize Cascade Eye Center to furnish information to insurance carriers concerning any diagnosis and procedures and I assign all payments otherwise payable to me to Cascade Eye Center.
6. **RELEASE OF INFORMATION:** I hereby authorize Cascade Eye Center to release (verbally or in writing) confidential medical information to any entity, government agency, insurance carrier, or others who are financially liable to Cascade Eye Center for charges for medical treatment, and for quality management, utilization review, transfer of medical care, and follow up purposes.

   I have read, understand, and agree to the practice's office and financial policies and I agree to be bound by its terms.

_____ _____

Signature of Patient/Guarantor (if applicable) Date