Alpine Vision

FINANCIAL POLICY AND PATIENT AGREEMENT

The following disclosure information is required for you to read and sign prior to treatment.

Any co-payments specified by your insurance company must be paid at the time of service, as is stated by your insurance company and can not be billed at a later date. Acceptable forms of payment are cash, personal check, money order, credit card, or CareCredit. You will also be responsible for payment of any charges that your insurance company applies towards your deductible and will be billed accordingly. Our office will call your insurance company and attempt to obtain your benefit and eligibility information prior to your appointment; however, we are not always given accurate information.

Your insurance policy is an agreement between you and your insurance company. Our relationship is with you, not your insurance company. Therefore, all charges are ultimately your responsibility regardless of your insurance status. As a courtesy to you, the office will file insurance claims with all standard insurance carriers. You are responsible to make available to the office complete insurance information for accurate filing of claims. Insurance information includes 1) Any necessary referrals for primary and secondary insurance coverage, and 2) all forms of identification, benefits cards and documents.

By this agreement you also authorize the exchange of information relating to care and claims with your insurance company(s), physicians involved in the treatment, Medicare, the employer (for work related injuries), and authorize insurance payments to be made directly to the office for services provided under your insurance agreement and otherwise payable to you.

In the case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs it is the authorizing parent's responsibility to collect from the other parent.

Any account more than 90 days past due is subject to collection proceedings. In the event that an account is turned over to a collection agency, you or the responsible party will be held responsible for payment of a 35% collection charge that will be added to the account balance. This includes court costs should your account go to litigation. Special financial arrangements can only be made with an addendum to this document.

Our office has contracted our insurance billing with Medical Billing Alliance South, LLC and it will be necessary to provide this billing service with certain information in order to file insurance claims. Medical Billing Alliance South, LLC is HIPPA compliant, and will adhere to the Client Confidentiality as outlined in the Notice of Privacy Practices.

PATIENT AGREEMENT: I have read and understand the Financial Policy, HIPAA Privacy Practice Notice, and disclosure information and agree to the terms stated.

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Patient or Legal Guardian's Signature | Patient's Printed Name

_____ _____

Date | Patients Date of Birth