INSURANCE AUTHORIZATION & BINDING FINANCIAL AGREEMENT

Providing the best possible eye care involves a mutual understanding between patient and provider. Should you have any questions regarding the following policies, please ask for clarification. Our professional services are rendered to you, not your insurance company. Ultimately, payment for service is your responsibility.

RELEASE

I authorize Alpine Vision Center to release any information regarding my care to expedite claims or for records transfer should such events be required.

BILLING AUTHORIZATION

I hereby authorize Alpine Vision Center to bill my insurance company for service provided to me and to issue payment directly to the providing doctor's office until written notice is provided to cancel this authorization. While Alpine Vision Center makes considerable effort to verify my insurance coverage, benefits, and cost shares, I understand that such information is NOT an official or legally binding estimation of my out-of-pocket expenses. Ultimately, my final cost share is dependent on the decision of my insurance carrier. I understand that any copay estimates given to me prior to my examination may ultimately be different from the final decision of my insurance carrier.

I understand there may be medical findings during the course of my exam. I understand it is a violation of Alpine Vision Center's provider agreement with my insurance to bill such medically related services to my vision wellness plan. In this event, my medical insurance will be billed and understand I will be responsible for any applicable co-pays, cost-shares, and/or deductibles. I also understand that Alpine Vision Center will not neglect medical findings in order to bill my vision wellness plan as that would put Alpine Vision Center in direct conflict with its ethical obligations to the Idaho Board of Optometry.

FINANCIAL RESPONSIBILITY

I agree that I am directly and fully responsible to Alpine Vision Center for payment of all charges, including any amount in excess of previous copay estimates. I realize that if my insurance company fails to pay the anticipated balance in full, or if payment is not made within 45 days, it is my responsibility to pay the balance in full. Any Collection fees, attorney fees, court costs, etc., for the purpose of collection on delinquent accounts are also my financial responsibility. In the event that I receive payment from my insurance company for services provided in this office, I agree to endorse any received payment to Alpine Vision Center.

If hardware is not paid in full within 6 months from date of order, all partial payments are forfeited and hardware will be returned. All sales are final on custom products.

I understand there is a $20 fee for all returned checks.

iWELLNESS DIGITAL IMAGING

Common sight-threatening diseases such as glaucoma, macular degeneration, and diabetic retinopathy often have no outward signs or symptoms, which is why regular eye exams including a thorough retinal evaluation are important to protect vision. To provide the most thorough eye exam, Alpine Vision Center has incorporated the iWellnessExam SD-OCT retinal scan as part of our comprehensive eye exams. Similar to an MRI or ultrasound, this technology allows our doctors to analyze the internal structure of the retina in ways not possible with traditional examination techniques. iWellness imaging is performed as part of your pre-examination work-up. Your doctor will then review the scans during your exam and the results made part of your permanent medical record for future comparison. Our doctors recommend iWellness scans starting at age 18 and every 2 years thereafter for otherwise healthy patients.

THE FEE FOR THIS PROCEDURE IS $29 AND IS NOT BILLABLE TO INSURANCE BUT IS ELIGIBLE FOR HEALTH/FLEXIBLE SPENDING ACCOUNTS.

[ ] I do NOT authorize the assigned practitioner to perform the iWellness screening.

I UNDERSTAND AND AGREE TO ALL STATEMENTS MADE HEREIN AND UNDERSTAND THIS IS A LEGALLY BINDING AGREEMENT.

X _____ _____

Signature Date

HIPAA / NOTICE OF PRIVACY PRACTICES

By signing below you attest that you have received, reviewed, and understood this practice's privacy policy and the rights to privacy that you are afforded by federal legislation (HIPAA Privacy Act). The privacy policy outlines how your information is shared only for the purpose of performing service or collecting payment. These policies are subject to change without notice.

X _____ _____

Signature Date

I AUTHORIZE INFORMATION MAY BE RELEASED TO THE FOLLOWING INDIVIDUALS:

_____ _____

Name Relationship

_____ _____

Name Relationship