# Precision Family Eye Care

**3848 Veterans Memorial Blvd., Suite 202, Metairie, LA 70002**
**Phone: 504-881-1242 Fax: 844-231-8899**

## OFFICE FINANCIAL POLICY

**Fees & Payments: As a courtesy to its patients, Precision Family Eye Care is pleased to assist in the submission of vision insurance claims to insurance companies for payment. I understand that it is my responsibility to confirm that Precision Family Eye Care is a participating provider under my policy. Further, I understand that my insurance company may not cover 100% of my bills for services and/or goods provided, and that I will be responsible for payment of any remaining balance due. This acknowledgment will serve as an advanced beneficiary notice for non-covered services.**

**I understand that it is my responsibility to provide Precision Family Eye Care with appropriate and current insurance information- and to notify Precision Family Eye Care immediately upon any change in my insurance coverage- to ensure efficient claims billing and payment. In the event that I fail to provide all necessary and current insurance information, I understand that my insurance company(ies) may deny payment of claims relating in services and/or goods rendered to me, and I understand that I may be fully responsible for my entire account balance.**

**Collections Fees: In the event of failure to pay for the services and/or goods rendered, I understand that I may be referred to a collections agency for non-payment of fees due for services and/or goods rendered by Precision Family Eye Care. I understand that I will be responsible for 30% collection fee, all agency and attorney fees and cost associated with the collection process (such as court cost), and that these fees and cost will be added to my account balance. I understand that i will be responsible for paying the entire amount of my balance due in addition to the collection agency fee. Further, I understand that my PHI will necessarily be revealed in these efforts to collect payment for money owed.**

**Assignment of Benefits: I hereby authorize payment of all vision insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to Precision Family Eye Care for services and/or goods rendered. I further consent to the use and disclosure of protected health information as regulated by HIPAA, and authorize the release of any information needed for the purpose of treatment, payment and health care operations, including, but not limited to the processing these insurance claims. A copy of this authorization may be used in place of the original.**

**I UNDERSTAND THAT ALL FEES FOR SERVICES AND/OR GOODS PROVIDED ARE DUE ON THE DATE OF SERVICE. I UNDERSTAND THAT I MUST RENDER PAYMENT IMMEDIATELY. I, THE UNDERSIGNED HAVE READ AND UNDERSTAND THIS INSURANCE INFORMATION & PAYMENT AGREEMENT. I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL, OR OTHER INFORMATION NECESSARY TO PROCESS THE INSURANCE CLAIMS, OR OTHERWISE OBTAIN PAYMENT, AND ACCEPT FULL RESPONSIBILITY FOR PAYMENT OF ANY FEE(S) NOT COVERED BY INSURANCE.**

**I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN LLEU OF THE ORIGINAL**

**Patient Signature/or Parent or Guardian:_____**

**Patient Print:_____ Date:_____/_____/_____**