PATIENT AGREEMENT FORM REGIONAL EYECARE ASSOCIATES

June 1, 2019

INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Regional Eyecare Associates on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the CMS 1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown and authorizes my doctor to act as my agent, as above.

AGREEMENT OF RESPONSIBILITY

I agree that professional services are rendered to the patient and the patient is responsible for charges incurred for these services. Payment for annual deductibles and coinsurance may be collected at the time of service. I agree that I am financially responsible for charges not covered by my insurance company. I agree that if my insurance plan requires a referral, it is my responsibility to get this referral prior to my appointment and present it to Regional Eyecare. I agree that if I fail to do this, I will be responsible for any charges incurred as a result of not having a referral.

PERMISSION TO CONTACT VIA CELL-PHONE OR EMAIL

We need permission to contact you by cell phone, mobile, or any other wireless number you have or may attain. Signing this agreement will allow us to do that. It will also allow any other person or entity to contact you regarding collection of any amounts you may owe for any past or current accounts such as a collection agency. You also expressly authorize us, and any other person or entity who provides goods or services to you in connection with this agreement, to contact you by sending text messages or emails to any of your telephone numbers or email accounts. Methods of contact may include the use of pre-recorded voice messages and the use of an automatic telephone dialing system. You acknowledge that such calls could result in charges to you by your telephone carrier.

OUT OF NETWORK PLANS

Although we make every effort to assist you in taking advantage of your insurance benefits, it is your responsibility to determine if our doctors are providers of your specific plan. There are plans that we are not providers for, including but not limited to Exclusive Choice, BCBS Mercy, Cigna Connect, etc. Even though we are not providers for these medical plans, we may be providers for your vision plan.

DEFAULT ON PAYMENT

I agree that if I default on payment and this is turned over for collection, I am responsible for the collections fee of 30%. In addition, if legal action is required to recoup payment, I may be responsible for the legal costs.

NO-SHOW FEE

I agree that Regional Eyecare may charge a fee of $25 for missed scheduled appointments.

INSUFFICIENT FUNDS POLICY

Any payment returned due to insufficient funds will immediately be reversed to that account and a $35 service charge imposed.

CONSENT TO TREAT

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her judgement.

and/or

I authorize the doctors of Regional Eyecare Associates to examine my eyes and related structures and to perform indicated procedures

Print Patient Name:____

__________________________	__________________________	__________________________
Signature of Responsible Party	Printed Name of Responsible Party	Date