McFADYEN FAMILY EYECARE, Inc.

A MEMBER OF VISION SOURCE®

Financial Policy Statement

To help our patients fully understand our billing process, we ask that you read and sign our financial policy statement.

As a courtesy to you, McFadyen Family Eyecare, Inc. will submit a claim to your insurance carrier. Depending on your individual policy, your coverage, your deductible and/or co-payment requirements, you are responsible for any balance not paid by your insurance.

Although McFadyen Family Eyecare, Inc. participates with most insurance carriers, *it is your responsibility* at the time of service to verify your insurance carrier and it the particular physician or the service/test that you are scheduled to have is accepted by your plan.

For claims not submitted as a courtesy, McFadyen Family Eyecare, Inc. accepts cash, debit cards, Master Card, Visa, American Express, and Discover. For insurance plans that do not allow courtesy submission of claims, you must pay at the time of service.

When our Doctor participates fully in your insurance plan, you are still responsible for paying co-insurance, deductible or co-payment(s) as indicated by your carrier, as well as any non-covered services under their contract. Once payment has been made or payment has been denied by the insurance company, you will be billed and be responsible to pay the balance.

Although McFadyen Family Eyecare, Inc. may on occasion and as a courtesy to you file private insurance claims, we will not become involved in disputes between you and your insurance carrier regarding covered charges, secondary insurance issues or "usual and customary" charges other than supply factual information as required by the insurance carrier.

Thank you for taking the time to review the McFadyen Family Eyecare, Inc. financial policy statement. Please let us know if you have any questions, comments, or special concerns.

I have read and agree with the financial policy statement of McFadyen Family Eyecare, Inc.

Responsible Party Signature: _____

Printed Name: _____ Date: ____/____/_____

SIGNATURE ON FILE

- I authorize McFadyen Family Eyecare, Inc. to use my name on any and all claims or documents that relate to health insurance benefits due to me, my dependents, and parties for which I am responsible.
- I authorize release of any information related to any claims to all my Insurance Companies or other relevant parties.
- I understand that I am responsible for my bill and agree to pay all charges for services and items provided to me.
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
- I authorize payment of health benefits otherwise payable to me, directly to my doctor.
- I permit a copy of this autorization to be used in place of the original.
- The "Signature on File" is valid for one year from the date indicated below.
- I understand that glasses are a custom-made product, therefore no refunds will be given on glasses that have been ordered. If there is a problem with your glasses, we will work with you to find a solution.

Any changes in glasses must be made within 60 days of purchase.

_____ _____/_____/_____

Signature of patient or responsible party Date

_____ _____

Printed Name of patient or responsible party Relationship to Patient

ACKNOWLEDGEMENT OF HIPAA

I acknowledge that I have read or received a copy of the Privacy Practices of McFadyen Famiy Eyecare, Inc.

Patient Name (Print): _____

Signature: _____ Date: ____/____/_____

Please list anyone you would like us to be able to release information to about the health of your eyes (spouse/partner, parent, children, etc...

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