3Visions Ophthalmology

Financial Policies and Patient Responsibility

I understand that 3 Visions ophthalmology, my treating physicians, and their respective designees, will use and disclose my health information for all purposes necessary for treatment, payment and health care operations, including but not limited to the release of information requested by my insurance company (or carrier) and any information necessary for the purpose of discharge planning.

- ASSIGNMENT OF INSURANCE**:** I hereby authorize my insurance benefits to be paid directly to 3 Visions Ophthalmology. I understand I am financially responsible for non-covered services. I authorize the release of any medical or other information necessary to process insurance claims on my behalf.
- FINANCIAL LIABILITY: I have been provided a copy of the 3 Visions Ophthalmology financial policies and agree to the specified terms. I hereby agree to pay all charges due (or to become due) to 3 Visions Ophthalmology for care and treatment, including copayments/coinsurance and deductibles as provided under my plan. Benefits, if any, paid by a third party, will be credited on account. I understand that I will be responsible for any charges if any of the following apply.
    1. My health plan requires prior authorization and or a referral by a Primary Care Physician (PCP) before receiving services at 3 Visions Ophthalmology and I have not obtained such a referral or I receive services in excess of the referral, and / or
    2. My health plan determines that the services I receive at 3 Visions are not medically necessary and / or not covered by my insurance plan, and / or
    3. My health plan coverage has lapsed or expired at the time I receive services at 3 visions Ophthalmology and / or

4. I have chosen not to use my health plan coverage, and / or
5. The Physician I see does not participate with my healthcare plan

- MEDICARE SIGNATURE ON FILE (Medicare patients only) : I request that payment of authorized Medicare benefits be made either to me or on my behalf to all providers who treat me during my office visit or the services provided to me by the suppliers. I authorize the holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Patient's Medicare Number _____

Patient's Signature_____

- CANCELED OR NO SHOW APPOINTMENTS: I understand that, based on the policy of individual physician office, I may incur a cancellation fee if I do not provide the required notice of cancellation, or if I do not keep my appointment and have not canceled **.** ** If you can not attend your appointment cancellation notice is required 24 hours **

I have been provided the 3Visions Ophthalmology Financial Policy. I understand that the information listed above which has been fully explained to me.

_____ _____

Patient Signature Date

_____ _____

Signature of Guarantor Date