VISIONARY EYECARE

ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT, SIGNATURE ON FILE

Assisting in the filing of your primary and secondary insurance claims is a courtesy we extend to our patients.

PAYMENT FOR SERVICES RENDERED

All co-payments, co-insurance, deductibles and fees for non-covered services are due at the time of service. If payment is not received from the insurance company within thirty (30) days, you may receive a statement, and we will expect payment from you. Any account that reaches a 90-day status is in jeopardy of being turned over to a credit bureau for collection. We accept cash, checks, Mastercard, VISA, Discover or debit card.

COVERAGE & NETWORKS

As health care providers, our relationship is with you (the patient), not the insurance company. Insurance contracts are between you and the insurance company. Accordingly, it is your responsibility to know your benefits, coverage, limitations, and/or networks.

MEDICARE / MEDIGAP AUTHORIZATION (Medicare patients only)

I request the payment of authorized Medicare/Medigap benefits be made on my behalf to Visionary Eyecare for any services provided to me by that provider of care. I authorize any holder of medical information to release to Social Security Administration, Centers for Medicare and Medicaid Services and/or its agents any information needed to determine these benefits or benefits payable for related services. I understand my signature requests that payment be made to Visionary Eyecare and authorizes release of medical information necessary to pay the claim.

RELEASE OF INFORMATION & BENEFITS

I authorize payment of insurance benefits directly to Visionary Eyecare and promise to assist in the processing of claims for benefits. I authorize any holder of medical or other information about me to release such information to my insurance carrier or its agents as needed to determine these benefits or the benefits payable for related services. Visionary Eyecare may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract with Visionary Eyecare for reimbursement for services rendered, and (2) any health care provider for continued patient care. Visionary Eyecare may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation.

FINANCIAL AGREEMENT

I have read and understand the payment policies of Visionary Eyecare. By signing this agreement, I accept full financial responsibility for any and all charges incurred to my account.

Patient's Name (Please Print):_____

Signature of Patient /Authorized Party:_____ Date:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

By signing this form, I acknowledge that I was offered and/or have read a copy of the Notice of Privacy Practices for Visionary Eyecare and Dr. Kelly P. Dice.

Patient's Name (Please Print):_____

Signature of Patient /Authorized Party:_____ Date:_____