



INSURANCE AUTHORIZATION AND BINDING FINANCIAL AGREEMENT

Providing the best possible eye care involves a mutual understanding between patient, staff, and doctor. Should you have any questions regarding the following policies, please ask for clarification. Our professional services are rendered to you, not your insurance company. Therefore, payment for our services is YOUR RESPONSIBILITY. By signing below you are attesting that you understand and agree to our policies as stated.

- ❖ I authorize this office to release any information regarding my care to expedite claims or for records transfer should such events be required.
- ❖ I hereby authorize this office to bill my insurance company for services provided to me and with payment made directly to the providing doctor's office.
- ❖ In the event that I receive payment from my insurance company for services provided in this office, I agree to endorse payment received to the doctor's office.
- ❖ **I understand and agree that I am directly and fully responsible to the physician optometrist for payment of all charges. I understand that such payment is not contingent upon on any settlement, judgment, insurance decision, or insurance payment by which I eventually recover said fee. I realize that if my insurance company fails to its anticipated balance in full or payment is not made within 45 days, it is my responsibility to pay the doctor's bill and that I will pay collection fees, attorney's fees, court costs, etc. for the purpose of collection on delinquent accounts.**
- ❖ I understand there is a \$35 fee for all returned checks.

I understand and agree to all statements made herein

Signature: _____ Date _____

Witness _____ Date: _____

NOTICE OF PRIVACY PRACTICES

By signing below you attest that you have received, reviewed, and understood this practice's privacy policy and the rights to privacy that you are afforded by federal legislation (HIPAA Privacy Act). The privacy policy outlines how your information is shared only for the purpose of performing service or collecting payment. These policies are subject to change or modification without notice.

Signature _____ Date _____