

ARCHDALE EYECARE
PAYMENT AGREEMENT

ACCOUNT PAYMENTS:

In order to minimize your health care costs, we request payment of all non-contracted fees and co-payments when services are rendered. All private insurance plans represent a contract between yourself and the insurance company. These contracts are not between the doctor and the insurance company. We will do our best to help you obtain benefits, but we cannot be responsible if your Carrier does not pay. Therefore, it is your responsibility to make certain your carrier makes prompt payment, and handles any disputes that may arise.

ASSIGNMENT OF BENEFITS:

If we have a "Participating Contract" with your insurance Carrier, we will accept assignment on all covered services and bill your Carrier for you.

AUTHORIZATION TO RELEASE INFORMATION:

I authorize the Clinic to release diagnostic and clinical information to third party payers and/or their reviewing contractors, who may be responsible for payment of services provided to me at the Clinic, when such information is needed to determine coverage for a Claim or other related claims. I also authorize clinical information to be released to referring physicians and other facilities for the purpose of my continued health care.

NON-COVERED SERVICES:

I understand that Medicare and some insurance companies do not cover refractive services. This is the part of the exam in which the doctor is determining if a spectacle prescription or change is needed. The cost of this service and any other non-covered service provided has been explained to me.

If your insurance has not paid the **FULL BALANCE** within 45 days from the date of service, you are asked to pay the balance in full.

If at any time you have questions regarding any treatment, fees, or services, please discuss them with us promptly and frankly.

I have read the policies and agree with the terms outlined above. I acknowledge that I am responsible to pay all charges for service rendered by Archdale Eyecare as outlined above. If accepting assignment, I authorize my private or secondary insurance to submit payment directly to this physician or clinic for coverage of services rendered under his/her care.

Responsible Party Signature: _____

Printed Name: _____ Date: _____