Patient Name_____

EAGLE VISION
SUPERIOR FAMILY EYE CARE

FINANCIAL POLICY

Thank you for choosing Eagle Vision as your eye health provider. Please understand that payment for provided services is due at the time services are rendered. We accept Cash, and Credit Cards (Discover, Visa, or Master Card).

If You Have Insurance

When we are a Participating Provider, all applicable Co-Payments, Deductibles, Lens Fitting, and Refraction charges, which are not covered by your Insurance Company, are due at the time the service is provided. Refraction tests are $30.00 and are necessary to determine if your eye prescription has changed, or if glasses will be necessary to correct vision. Medicare and many supplemental insurances do NOT cover this test. All non-covered services, such as refraction testing, will be the responsibility of the patient and are due at the time of service.

When we are NOT a Participating Provider, the patient is fully responsible for all charges. We will bill your insurance company; however, the remaining balance of the bill is your responsibility, whether or not your insurance company pays. Your insurance policy is a contract between the insurance company and yourself. Please note that some, perhaps all, of the services provided may be non-covered under the Medicare program.

Interest and Collection Fees

All returned checks, regardless of reason, will be assessed a $20.00 fee and any additional collection expenses incurred to recover the original amount due for the medical services rendered.

By signing below I agree to pay all amounts owed within 30 days of when such amounts are incurred. I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein. I agree that interest will accrue on all past-due amounts at the rate of 18% per annum (1.5% per month) until paid in full. In the event any amount(s) is/are referred to a third party dept collection agency, I agree that in addition to any other amount(s) allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee of up to 40% of the principle amount(s) owing as allowed by Utah Code Annotated, sec 12-1-11. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today. I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me.

Signature_____ Date_____

Signature of Patient or Responsible Party

Print Name_____

HIPAA Disclosure

We are required to notify you of our privacy practices and have you sign that you have reviewed this information. Eagle Vision maintains a record of each patient visit, describing your history, symptoms, exam findings, diagnosis, and suggested treatment. Medical records are needed to provide you with proper care, coordinate with other physicians involved with your care, and for communication with your insurance company. We do not share your personal medical information with any unauthorized entity without your permission. More details of your Notice of Privacy Practices may be found in our written publication.

I have been given access to Eagle Visions Notice of Privacy Practices, which describes how my health information is used and shared. I understand that Eagle Vision has the right to change this notice at any time.

My signature below acknowledges that I have read and understand the Notice of Privacy Practices.

Signature_____ Date_____

Signature of Patient or Responsible Party