CREEKSIDE
VISION & HEARING

FINANCIAL POLICY

We recognize the need for a definite understanding between patient and physician regarding financial arrangements for medical care. Responding to this need, we have established the following financial policy. Please take a moment to read through the policy, sign it, and return it to this office at the time of your visit. If you have any questions regarding this policy, please do not hesitate to ask us.

You are responsible for your deductible, your co-payment amounts and any services not covered by your insurance. We require that payment for any of these out-of-pocket expenses be made at the time of service. If this is not possible, please make payment arrangements with our billing office before your scheduled appointment.

We participate with many health, vision and hearing plans. When we participate with a benefit plan, we agree to submit claims for the services we provide to our patients, and we agree to accept the "approved amount" as payment in full for the covered services we provided. The approved amount often includes a specific amount that is the responsibility of the patient to pay. The portion that the patient is responsible for is usually referred to as co-payments, deductibles or co-insurance. It is our policy to collect this amount at the time of service.

If you have benefits through a plan we are not contracted with, payment is expected at the time of service. Please remember that your insurance coverage is a contract between you, your employer and your insurance company. We will submit one courtesy claim to a commercial carrier for you, however all charges are your responsibility and will be due at the time of service.

I have read and understand the above Financial Policy.

Signature_____ Date_____

ASSIGNMENT OF INSURANCE BENEFITS

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of my patient records.

I hereby agree to a transfer of benefits for all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance and other health plans to the providers of Creekside Vision & Hearing, P.L.C.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges not covered by my insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Patient/Parent/Guardian Signature_____ Date_____