Hogle Eyecare Center

Authorization to Bill Insurance and Billing Policies
(Effective Date: 07/01/2013)

Our goal is to provide you with the best medical eye care available. In order to achieve our goal and minimize escalating administrative costs, we ask for your understanding and cooperation regarding the following payment/insurance policies:

1) We ask that payments be made at the time of your visit unless other arrangements have been made in advance. I understand that **Co-pay's are required by insurance companies for each visit warranted.** Hogle Eyecare Center does not set prices for co-pays and is required by contract with each insurance company to collect co-pays at every visit.

2) If you are a member of an HMO or PPO plan you need to have a VALID referral for each office visit. Please call our office in advance to make sure you have the necessary forms and authorization.

3) It is our policy to render periodic statements for services on a monthly basis. In the event our statements for services are not paid within sixty (60) days after you receive an invoice, we reserve the right, at our option, to charge interest on the balance due, at a rate of one-and-one-half percent (1½%) each month.

4) Our payment policy also requires that payments for services and materials are expected at the time of service for all patients. I hereby authorize direct payment of medical/vision benefits to Hogle Eyecare Center for services rendered in person or at the practice. **I understand that I am financially responsible for any balances not covered by my insurance plan.**

5) I authorize Hogle Eyecare Center to release any medical or incidental information that may be necessary to bill my insurance.

6) **I understand that some diagnoses/procedures require billing to my medical insurance and some to my vision insurance,** depending on current standards of practice. I authorize Hogle Eyecare Center to bill services and materials to the insurance type that they deem proper. I understand that Hogle Eyecare Center will work with me to determine my best options financially and medically.

Medicare Patients:

I request that payment of authorized Medicare benefits be made on my behalf to Hogle Eyecare Center for any services furnished me by those physicians. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits or benefits payable for related services.

HIPPA

I agree to and understand that Hogle Eyecare Center complies with all requirements of HIPPA and my rights to my records and their privacy. I understand that there are full copies of the HIPPA statement available at the front desk.

I accept and understand the above policies as outlined above.

Signed (Patient or Guardian)____ Date:_________________