KANE COUNTY EYE CARE

Patient Name:__________________________________

FINANCIAL POLICY

Thank you for selecting Kane County Eye Care (KCEC) for your optometric care. We are committed to providing the best eye care possible. The following information outlines financial responsibilities related to payment for services rendered.

You, the patient, are ultimately responsible for all charges associated with your care. KCEC participates with a wide variety of insurance plans. We refer to "in network" as the insurance companies that we have a contract agreement with. Please be aware, you incur more out of pocket expenses for seeing a doctor "out of network." It is your responsibility to check your insurance company for coverage and participation details. We will submit insurance claims on your behalf to your primary insurance and forward on to your secondary insurance carrier. However, it is important to remember that your insurance is a contract between you and your insurer and it is your responsibility to know and understand the requirements of your insurance plan. We will not be responsible if you do not follow the specific terms of your insurance agreement and if we do not receive payment from them, you will be responsible.

It is your responsibility to:

1. Bring your insurance card to every visit.
2. Be prepared to pay for your co-pay and non-covered services at each visit.
3. Obtain any referrals that your insurance requires.
4. Provide a valid mailing address.

Failure to provide any of the above may require you to pay in full or reschedule your visit.

Payment is required when services are rendered (eye exams, contact lens fits, office visits, etc.)
All glasses and contacts must be paid in full before they can be ordered.
There will be a $30.00 fee on all returned checks.
I understand that I am responsible for my bill even if my insurance denies my claim or if the claim is not paid within 90 days.

If there is a remaining balance due after your insurance carrier pays, you will be billed. If that balance is not paid in full within 60 days, there will be a $15.00 late fee added to your account. Balance must be paid in full by the end of a 90 day period or your account will be turned over to our collection agency. **Payment arrangements can be made, but it is your responsibility to contact our office before it is turned over to an outside agency.**

We accept cash, check, Visa, Mastercard, Discover, American Express, and Care Credit.

If the patient is a minor, the parent or guardian must sign below. The parent, guardian, or unaccompanied minor is responsible for any payment due at the time of service and supplying insurance cards for proper billing.

Our office will do all we can to assist you. If you have any questions or concerns, please do not hesitate to contact our office.
Kane County Eye Care believes that a good physician/patient relationship is based on understanding and communication.
By signing below, I agree to pay all amounts owed within 30 days of when such amounts 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 amounts are referred to a third party debt collections agency, I agree that in addition to any other amounts 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 principal amount owing as allowed by Utah Code Annotated, sec. 12-1-11. The terms of this paragraph shall apply to all amounts incurred by me or by any individual for whom I have legal responsibility whether such amounts are incurred today or after today.

I do hereby agree to make the above payments and agree to the terms and conditions thereof.
I hereby agree to abide by the conditions outlined above.

____ ______________________

Patient/Guardian Signature **Date**

KANE COUNTY EYE CARE

PRIVACY PRACTICE ACKNOWLEDGEMENT

By signing this form, you acknowledge you have been informed that Kane County Eye Care provides information about how we may use and disclose your Protected Health Information (PHI).

Kane County Eye Care may use the following methods of communication regarding information related to my personal health, treatment or payment for treatment. I acknowledge I am responsible for updating this information as necessary. This request supersedes any prior request for methods of communication.

_____ Home Phone ____

_____ OK to leave a message with detailed information

_____ Leave call back number only

_____ Cell Phone ____

_____ OK to leave a message with detailed information

_____ Leave call back number only

Name (please print):____ Date:__________________________________

Signature:____ Relationship to Patient: ☐ Self ☐ Parent ☐ Legal Guardian

PERSONAL REPRESENTATIVE DESIGNATION

This section allows you to give Kane County Eye Care permission to discuss your Protected Health Information with a person(s) you appoint as your Personal Representative. You are not required to name a personal representative, but if you do not, we will not disclosed your Protected Health Information to someone who may call on your behalf. Your Personal Representative may be anyone of your choosing such as a spouse, parent, child, or friend. You may revoke this designation of a Personal Representative at any time by giving written notice to our office.

☐ **I decline to name a Personal Representative** **OR Designate Representative(s) below**

1. Personal Representative

Full Name:____ Relationship:____

Cell Phone:____Home Phone (if different):____

2. Personal Representative

Full Name:____ Relationship:____

Cell Phone:____Home Phone (if different):____

3. Personal Representative

Full Name:____ Relationship:____

Cell Phone:____Home Phone (if different):____

4. Personal Representative

Full Name:____ Relationship:____

Cell Phone:____Home Phone (if different):____