Liberty Lake EyeCare Center

FINANCIAL POLICY

Payment in full, for all products and services, is expected at the time of service, except for those covered by your insurance policy. I understand that I am personally responsible for any amounts not covered by insurance. I agree to pay interest at the rate of twelve percent per annum on amounts which remain unpaid for more than 30 days.

INSURANCE BILLING POLICY

As a courtesy to our patients, Liberty Lake EyeCare Center, PS., agrees to submit a claim, on behalf of the patient, to insurance carriers for which we are providers.

~ *Deductible and co-payment are due at the time of service.*

If your insurance is through a managed health care program, we are obligated to follow your service contract regarding referrals to other specialist, even when that means a delay in your care.

Due to insurance limitations, it may not be possible to obtain a referral from your primary care physician after you have already received treatment in our office. You may be responsible for the cost associated with services obtained without a referral.

~ *It is your responsibility to verify authorization for care with your insurance company. We are happy to assist you with insurance companies we are carriers for. While we do call insurance companies to receive benefit information, we cannot guarantee the accuracy of the information provided.*

~ *Please note: most policies pay only a portion of your total charges.*

~ *After payment is received from your insurance company, any remaining balance on your account past 30 days will be assessed a finance charge I understand and agree to these terms.*

INFORMED CONSENT

I authorize the doctors of Liberty Lake EyeCare Center, PS., to examine my eyes and related structures and to perform indicated procedures.

I authorize the release of medical information about me to my insurance carries(s) for the determination of benefits payable for services rendered and optical goods supplied by Liberty Lake EyeCare Center, P.S.

I give permission for Liberty Lake EyeCare Center, PS., to leave pertinent messages on my answering machine at home and/or at my place of employment, limited to request to return the phone call.

HIPAA CONSENT

I have been informed that I may review the Notice of Privacy Practices (for a more complete description of uses and disclosures) for Liberty Lake EyeCare Center, PS., before signing this consent.

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Print Name: ____

Signature of Patient: ____________________________________ Date: __________

If signed by patient representative, state relationship to patient: ________________________