ANDERSON SHAPIRO EYE CARE

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Anderson & Shapiro as your eye care provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that your read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

1. The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for their examination, treatment, and care.
2. We are pleased to assist you by billing our contracted insurers:
    a. Patients are required to provide us with correct and current information about their insurance.
    b. Patients are responsible for any charges incurred, in the event the insurance information provided is not correct or current.
3. Patients are responsible for payment of co-pays, co-insurance, deductibles and all other procedures or treatments not covered by their insurance plan.
4. We make every effort to accommodate you in a timely manner, when you need eye care services. In return, we expect that you make every effort to pay your bill promptly.
5. If a patient is uninsured, payment is due at time of service.
6. Insurance plans and Medicare consider some services to be non-covered. For example, Medicare does not cover routine vision exams. Therefore, Medicare beneficiaries are not covered for vision correction such as eyeglasses or contact lenses under Medicare Part B unless you need vision correction after cataract surgery. Medicare Part B also does not cover eye refractions. Medicare patients are responsible for payment of routine vision exam and refraction services.

Prompt Payment

7. Co-pays are due at the time of service, and for your convenience, we accept cash, checks, and most major credit cards.
8. Co-insurance, deductibles, and non-covered services are due upon receipt of a statement from our billing office.
9. Medicare patient payment for routine vision exams and refraction services will be collected at the time of service.

10. Patients may incur, and are responsible for additional charges, if applicable. The charges may include:
    a. Returned check charge.
    b. A $3.50 statement fee, if co-pays aren't paid at the time of service.
    c. Interest on unpaid amounts due over 30 days shall accrue at the rate of 18% per annum.

Patient Authorizations

1. I authorize Anderson & Shapiro, and the physicians, staff, and hospitals associated with Anderson & Shapiro to release medical and other information acquired during my examination or treatment to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate, coordinate, or pay for my care.
2. I authorize assignment of financial benefits directly to Anderson & Shapiro and any associated healthcare entities for services rendered as allowable under third party payor contracts. I understand that I am financially responsible for charges not covered by this assignment.
3. I authorize Anderson & Shapiro to communicate with me regarding my financial responsibility for services by mail, text, voicemail, or email, according to the information I provided during patient registration.
4. Optional Credit Card Storage Authorization:
    - By checking this box, I authorize Anderson & Shapiro to securely store my credit card information and only charge it should I have an outstanding balance. I am aware that the storage system used is fully compliant with the highest level of security regulations. Once stored, I am aware that only the last 5 digits of my card are viewable by Anderson & Shapiro business services staff.

My signature below indicates that I have read, understand, and agree to the provisions of Anderson & Shapiro's Patient Financial Responsibility Policies, described on this form.

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Patient Signature Date

Patient Printed Name _____

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Guarantor, Responsible Party, or Legal Guardian Signature Date

Guarantor, Responsible Party, or Legal Guardian Printed Name

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