FINANCIAL AGREEMENT

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the highest quality eye care using only the best equipment and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum eye health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your eye care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

Your estimated co-payment for treatment, which is the amount not covered by your insurance, is due at the time service is provided. Your estimated co-payment may be adjusted after the time of service depending upon the final reconciliation of the insurance benefit payment. Our office accepts cash, personal checks, MasterCard, American Express, and Visa. In addition, we offer outside financing available through Care Credit.

For your convenience our office takes personal checks. However, a ***$30.00*** *fee* will be applied to an account for any bounced check and from that point forward, personal checks will no longer be an acceptable form of payment.

A **refraction** is performed as part of a normal eye examination. This test determines the best vision possible and provides a prescription for glasses if needed. It is also needed to determine if any medical, optical or surgical treatment may be indicated. It is a necessary part of an ophthalmic examination, but it is NOT a covered service by Medicare and some insurance companies. Our office fee for the refraction is **$40.00** and this fee is collected in addition to any co-payment, co-insurance, or deductible.

By signing the form below you are agreeing to the following:

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor child. I accept full financial responsibility for all charges not covered by insurance.

I, the undersigned, agree to be responsible for the balance of my account. Although an insurance claim (if applicable) will be filed with my insurance company by the doctor on my behalf, negotiating payments through my insurance company ultimately is my obligation. If my insurance company requires a referral/authorization from my Primary Care Physician, I understand it is my responsibility to obtain this. If I have no insurance, I understand that payment will be made at the time the services are rendered unless

financial agreements have been made PRIOR to the services. A statement will be mailed to me each month showing the total balance due from me and will be considered past due within 30 days from receipt.

In the event my account balance remains unpaid in excess of 90 days, I understand that my account will be turned over to a collection agency. I accept full responsibility for all administrative costs and legal fees associated with the collection process.

I hereby authorize St. Louis Eye Institute to:

- Administer medical treatment as necessary for a patient in my condition.
- Release any and all information contained in my medical records pertaining to this treatment or series of treatments to my insurance company, third party carriers, or their representatives, and referring or consulting physicians.
- Authorize payments of medical and surgical benefits, provided by my insurance carrier, to St. Louis Eye Institute.

Signed: _____ Date: _____

Patient Name / Parent, if Minor

MEDICARE PATIENTS

In Medicare assigned cases, the physician agrees to accept the charge determination of the fiscal intermediary as the full charge. I understand that I am responsible for the deductible, co-insurance, and non-covered services. Co-insurance and deductible are based upon charge determination of the Medicare carrier if this is less than the charge submitted. Therefore, I request that payment of authorized Medicare benefits be made to me or on my behalf to St. Louis Eye Institute for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me needed to determine these benefits or the benefits payable for related services to be released to the Health Care Financing Administration and its agents.

Signed: _____ Date: _____

*This form does not authorize any above named person to make health care decisions for the above named patient or entitle them to paper or electronic copies of the patient's medical records.

We will not release, via telephone or any other means of communication, any information to any friends or family members not listed above, unless the patient has an opportunity to object and does not (via documentation) or it is reasonable to infer that the patient does not object, such as when a patient brings a spouse into the exam room when treatment is being discussed. Exception: If the release is needed in an emergency situation.