Boshinski Eye Clinic

PATIENT NAME:_____

Financial Agreement

I request that payment of authorized Insurance benefits be made on my behalf to Boshinski Eye Clinic, for services furnished to me by Boshinski Eye Clinic. I understand that by my signature below I authorize release of medical information necessary to pay the claim. I am responsible for the copay, deductible, coinsurance and non-covered services. All known charges are due at the time of service.

MEDICARE and some insurances **do not cover a refraction**, which is the part of your exam which determines your prescription. That fee of $30 is due at the time of your visit.

All current insurance information must be presented at each visit. If you do not provide us with current insurance information you will be held financially responsible for the full charges. I understand I am individually obligated to pay the full charges of all services rendered to me by Boshinski Eye Clinic if I belong to a plan which is not contracted with Boshinski Eye Clinic.

PATIENT FINANCIAL AGREEMENT:

- I understand that I am solely responsible for payment of my bill.
- If my account becomes delinquent and is sent to an outside collection agency or attorney, I will be responsible for the collection costs (up to 35% of the balance due), to the extent permitted by law, along with reasonable attorney fees and court costs incurred by Boshinski Eye Clinic.
- I am aware that there will be a $35 charge per incident of returned checks.

Initials:_____

Privacy Statement and HIPAA

It is the physician's responsibility to ensure that the physician-patient relationship is confidential. HIPAA requires physicians to have permission on disclosing certain protected health information to family, friends, etc. We will coordinate benefits in the interest of coordination of care between other physicians and providers.

I hereby give permission to Boshinski Eye Clinic to release to the person(s) written below any information about my medical condition or medical needs or the status of my account. I also allow Boshinski Eye Clinic to coordinate my care between other physicians and providers. I release Boshinski Eye Clinic, its physicians and staff, from any claim of confidentiality in connections with the release of this information.

Initials:_____

Name:_____Phone#:_____

Relationship:_____

Name:_____Phone#:_____

Relationship:_____

Vision vs. Medical Insurance

Vision and medical insurance are very different in terms of the services they cover and it's important for our patients to understand those differences. Vision coverage is for a wellness visit to determine a prescription for glasses and for screenings of eye health. Once there is a medical diagnosis, then medical insurance is filed on those services. When a medical condition is present (such as diabetes, cataracts, dry eye, floaters, etc.) it is necessary to file the visit with your major medical carrier and the copays for that insurance will apply as well as deductible, coinsurance, or any non-covered services. It is impossible for our office to estimate your cost, as all insurance plans are unique to each patient. In some cases, there is no way to know prior to the examination which type of insurance our office will be able to file for you. Your treatment decisions are made by Dr Boshinski solely on the basis of medical necessity and the availability of insurance coverage is not a factor in this decision making process.
I understand all the above information and agree to all terms stated.

Patient Signature:_____Date:_____

Witness Signature:_____Date:_____