INDIAN SPRINGS
EYE ASSOCIATES PC
945 Indian Springs Road, Indiana, PA 15701 ■ (724) 465-6232

FINANCIAL POLICY

Thank you for choosing our office as your eye care provider. The following is a statement of our financial policy. Please read carefully prior to any services performed.

NON-INSURED PATIENTS:

We ask that all cash paying patients requiring only services pay in full all charges at the time of services rendered. When purchasing materials such as contact lenses, glasses, etc., We require 50% deposit with the balance due upon delivery of those materials. All materials and solutions, which can be ordered and delivered on the same day, must be paid in full when ordered.

INSURED PATIENTS:

Your insurance policy is a contract between you and your insurance company. We will submit charges to your insurance company if we are a participating provider, and if you have given us all of the required information. We must have the most current copy of your insurance information or card. You must notify us immediately of any change in your insurance coverage. Our receptionist will try to gather most of this information when she schedules or verifies your appointment via telephone. Please be aware that some, and perhaps all of the services provided may be considered "non-covered services" according to your policy or your eligibility. You will still be responsible for payment of these services. ***If we are a non-participating provider with your insurance company,*** **you will be responsible for charges at the time of service.** We will assist in completion of any forms you have available the day of the appointment.

AUTHORIZATION AND REFERRALS:

At the time of your office visit, you are responsible for all professional fees and materials if referral or authorization is not received. Please check with our receptionist for the current list of insurance companies with which we participate. At the time of service we will collect the co-payment indicated by your insurance. You will be responsible for payment of any deductibles, co-insurance or non-covered services.

MINOR PATIENT (UNDER 18 YEARS)

The parent/guardian/adult accompanying a minor child is responsible for full payment. If both parents have insurance, the parent with the first birthday in the year is most often the primary insurance. Please check with your insurance carrier/policy to determine which company is the primary before the appointment. In divorce cases, the parent who brings the child in for services is the responsible party.

PAYMENT OPTIONS:

We accept all major credit cards (Discover, Visa, MasterCard, Debit Card), cash, and checks. PLEASE NOTE: There will be a $25 charge for any NSF (Insufficient Fund) checks returned to our office – plus any magistrate fees if further collection proceedings are deemed necessary.

COLLECTION BALANCES:

If you have had a previous collection balance or are presently in collection, it will be required that you pay your previous balance prior to being seen again or ordering any new materials. A late fee of $2 per month will be added to your bill if not paid by the next monthly billing statement.

I have read the above financial policy. I understand and agree to this financial policy.

_____ **INITIAL**

INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I request that payment of these benefits be made either to me or on my behalf to Dr. Keith S. Hilliard for any services and materials furnished. I authorize any holder of medical information about me to release in the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits payable to related services.
If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

_____ **INITIAL**

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received a copy of Dr. Keith S. Hilliard's Notice of Privacy Practices.

_____ **INITIAL**

HIPPA AUTHORIZATION

Please list the family members or other persons, if any, whom may be informed about your general medical condition and your diagnosis (including treatment, payment, and health care operations.)

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_____ **INITIAL**

MEDICAL WAIVER

It is my understanding if and when Dr Hilliard wants to do medical testing and/or medical procedures, that these tests will be billed to my medical insurance. I also understand that the full amount of these charges may not be covered by my insurance. If that is the case, I will be responsible for the balance. A statement will be issued by our billing provider.

Signature _____ Date _____

SIGNATURE FOR ABOVE POLICIES

I HAVE READ AND UNDERSTAND ALL AREAS WHERE I HAVE INITIALED ABOVE. MY SIGNATURE BELOW INDICATES THAT I UNDERSTAND AND AGREE TO THESE POLICIES.

_____ _____
Signature of Patient if Adult Date

_____ _____
Signature of Parent or Guardian (if patient is under the age of 18) Date