Forgues Eyecare & Associates

PATIENT FINANCIAL AGREEMENT AND ACKNOWLEDGEMENT OF OFFICE PRACTICES

Forgues Eyecare & Associates is committed to provide you with the best available vision and medical care. We believe that part of good healthcare practice is to establish and communicate our office and financial policy to our patients.

1. **PAYMENT** is expected at the time of your visit. We accept cash, check, Visa, Mastercard, Discover, American Express, Apple pay, CareCredit, FSA and HSA. Payment will include any coinsurance, co-payment amount, unmet deductible, and charges not covered by your insurance company. All non-filed services are to be paid at the time of service. We require full payment before any materials will be ordered. Materials not picked up within 90 days will be forfeited and a credit will be applied to your account for merchandise that can be returned to the manufacturer.
2. **RETURNED CHECKS** will incur a $50 service charge.
3. **PROFESSIONAL SERVICES** are non-refundable, including but not limited to, contact lens fittings, in-office testing, and the Optos® imaging.
4. **INSURANCE**: Insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. In the event your insurance denies the services provided, you will be responsible for the payment in full. If you have a plan that requires a referral to see a specialist, you must obtain a referral prior to your visit in our office to be covered under your medical insurance. If you do not have a valid referral and still wish to be seen, you will be asked to pay for the visit out-of-pocket in full. In order to bill your insurance and to meet filing guidelines we do ask for a copy of your insurance card and a photo ID. All insurance co-payments must be paid upon completion of services for the day.
5. **AUTHORIZATION TO BILL HEALTH INSURANCE**: I authorize and acknowledge that Forgues Eyecare will submit my claim to my insurance company on my behalf. I further understand that I will be held responsible for any amount of my medical bills not covered by my insurance policy or claims, and that I will be responsible for paying all deductibles, fees, co-payments, and co-insurance payments required. I understand that any portion of my medical bills not covered by insurance will be billed to me at the address I have provided. Non-compliance or defaulting on payments may result in denial of service and/or a legal claim against me for non-payment.
6. **CONSENT AND DISCLOSURES**: I voluntarily consent to medical treatment for myself and/or my dependents.
7. **DIVORCED PARENTS OF PATIENTS**: The adult who signs-in a minor child on the day of service accepts full responsibility for payment. It is not our policy to send bills or records to the other parent/guardian for the issue of payment or communication. We will communicate about treatment and payment with the parent/guardian present at the time of visit. Parents/guardians are responsible between themselves to communicate with each other about any treatment and payment issues.
8. **RELEASE OF INFORMATION**: I hereby authorize and direct the release (verbally and/or writing) of my medical information to other medical practitioners, insurance carriers, government agencies, or others who are financially liable to Forgues Eyecare for charges for my medical treatment, and for quality management, utilization review, transfer of medical care, and follow up purposes.
9. **NO SHOW POLICY:** It is requested that if you must cancel your appointment that you provide more than a 24-hour notice. Patients who do not show up, nor provide 24-hour notice, are considered a no-show. Rescheduling of appointment will be done on a next available basis.
10. **NOTICE OF PRIVACY PRACTICES:** A copy of Forgues Eyecare's Notice of Privacy Practices is available to me by the front desk. I acknowledge that I have been made aware of this notice.

I have read and understand the practice's office and financial policies and I agree to its terms.

Print patient's name:_____ Signature: _____ Date: _____

Please email this completed form to **WorcAdmin@ForguesEyecare.com** or you may bring it with you to our office.