Signature on File, Treatment Consent, and Financial Agreement

Patient Name: _____ Account Number: _____

SECTION 1: Consent for Treatment & Information Sharing

MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to The Center for Eye Care and Optical for services furnished to me. I authorize the release of any medical information needed to determine these benefits. The Center for Eye Care and Optical accepts the Medicare carrier's charge determination as the full charge, and I am responsible for deductibles, coinsurance, and non-covered services.

MEDIGAP: If indicated in Item 9 of the HCFA 1500 form or elsewhere, I authorize the release of information to secondary insurance providers. I request payment of authorized secondary insurance benefits to The Center for Eye Care and Optical or myself.

OTHER INSURANCE: I understand The Center for Eye Care and Optical's contracted health care service plans and agree to pay full charges if my plan is not listed.

RELEASE OF INFORMATION: I authorize disclosure of my medical record and/or financial ledger to entities liable or under contract with The Center for Eye Care and Optical. Information may also be disclosed for continued patient care, medical research, and as required by law.

SECTION 2: Acknowledgment of Services Rendered & Consent to Pay

I acknowledge that I have been informed about and discussed the costs of the treatment to be provided with a representative of the practice, and I am providing consent to treatment based on this discussion. I agree to pay for services rendered, including any applicable co-payments, deductibles, non-covered services, or additional charges. I understand that unpaid accounts may incur collection expenses and attorney's fees.

NON-COVERED SERVICES: I accept financial responsibility for services not covered by my health care service plan and agree to obtain necessary authorizations.

NOTICE OF POTENTIAL OUT-OF-NETWORK CHARGES: If The Center for Eye Care and Optical is not in-network with your insurance plan, you may receive a separate bill and may be responsible for charges not covered by your plan. You will be informed if your provider is out-of-network and provided with a Good Faith Estimate when appropriate. You will not be billed more than the in-network cost-sharing amount for emergency services or certain scheduled services unless you provide written consent.

GOOD FAITH ESTIMATE NOTICE (for Self-Pay or Uninsured Patients): You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost. If you are not using insurance or are choosing to self-pay, a Good Faith Estimate of expected charges will be provided in writing prior to your appointment, upon request, or when scheduling care. If you receive a bill that is at least $400 more than your Good Faith Estimate, you may dispute the bill. For questions or to learn more, visit: www.cms.gov/nosurprises If you believe you've been wrongly billed, you may contact the **Department of Health and Human Services (HHS)** at 1-800-985-3059.

CARD ON FILE CONSENT: I voluntarily authorize The Center for Eye Care and Optical to securely store my credit or debit card for future use. I may be contacted and charged for outstanding balances (including copays, deductibles, refractions, and late cancellation fees) if payment has not been received within 30 days. I will be notified prior to any charge being made. I understand that I may withdraw or update this authorization at any time. I understand this does not affect my right to receive care. I understand that use of a credit or debit card for payment of medical services means I am forfeiting state and federal protections related to medical debt, such as limits on interest, wage garnishment, or credit reporting.

REFRACTION POLICY: A comprehensive eye evaluation includes a Refraction and a Medical Eye Exam. The Refraction fee is $75.00. If your insurance is listed below, we will submit the charge to them. If not covered, the balance is your responsibility. All others must pay the fee at the time of service. Eyeglass prescriptions will be available at checkout once the Refraction fee is paid.

Usually Covers Refraction:

- Davis Vision
- Spectera
- Aetna
- EyeMed
- Superior Vision
- UHC Community Plan
- Blue Cross and Blue Shield
- March Vision
- UFT
- United Healthcare
- Medicaid

Sometimes Covers Refraction:

- NVA
- VSP

OTHER FEES: A $25 charge applies if payment is not received at time of service. A $50 fee applies for appointments canceled or missed without 24 hours' notice.

PAYMENT OPTIONS: We accept payment by Cash, Check, or Credit/Debit Card or HSA/FSA Card. You are not required to provide a card on file in order to receive medically necessary or emergency care.

SIGNATURE & ACKNOWLEDGMENT

I have read and understand the policies above. I agree to the terms as described and acknowledge financial responsibility for services received. *Any changes, additions, or deletions made by the undersigned to this form shall be considered void and will not alter the terms of our policies.*

Signature: _____ Date: _____