

Patient Financial Responsibility Form

CANCELLATION AND "NO SHOW POLICY": Patients are expected to cancel **"at least 24-48 hours in advance of their scheduled appointments."** **NOTE:** If you cancel an appointment on the same day of your appointment or fail to come to your appointment "No Show" you may be charged a No Show Fee of \$25.00. This notification is necessary in order to adequately allow us to reschedule you and/or fill your spot.

_____ (Please initial that you have read and fully understand this policy)

FINANCIAL POLICY:

I certify the information I have reported is correct. I understand that it is the policy of this office that I'm responsible for obtaining pre-approval (precertification) from my health insurance carrier if that is needed. Furthermore, I understand that it is in my own best interest to ascertain what my related benefits are with my health insurance carrier and to know whether I have a co-pay, deductible, co-insurance or any other fees that I might have to pay Envision Eye & Laser Center/Advanced Eye Care Medical Center, PA.

I hereby assign and transfer to Dr. Renee Bovellev of Envision Eye & Laser Center/Advanced Eye Care Medical Center, PA my health insurance benefit payments. I also authorize the release of any medical information needed to determine my benefit payments.

I also fully understand that while Envision Eye & Laser Center will assist me in billing my insurance company that ultimate responsibility is mine. Additionally I agree that in the event of non-payment for services provided, to accept full and complete responsibility for the balance due, to accrue interest on my outstanding balance at the legal rate of 8% per year, collection costs, court costs and reasonable attorney fees should that action become necessary and as allowed by law.

_____ (Please initial that you have read and fully understand this policy.)

CONFIDENTIALITY: As a health care specialist it may be necessary to communicate in writing, phone, fax or electronic transmission to your primary care physician, other health care providers, health insurance companies, Medicare/Medicaid or health insurance clearinghouses, etc. Communication between your health care professionals is in your best interest as it helps coordinate your medical care. Furthermore, health insurance companies may require certain information that you have agreed to be released as a participating member.

Envision Eye & Laser Center's practice will make its best efforts to protect your privacy. This includes nondisclosure of your personal information for marketing and fund-raising purposes. I understand and agree that my personal health information may be transmitted electronically to consulting health care practitioners to facilitate my medical care.

I acknowledge that I have had an opportunity to read the office's Notice of Privacy Practices and Health Care Disclosure Information that contains a description of the uses and disclosures of my personal health information. I understand that this information may be updated and I will be able to see the new information. The Policy of this office is to strive to be in compliance with federal and state medical practice guidelines.

Patient's Name _____ (Please Print) Date ____/____/____

Signature of Patient _____

Signature of Responsible Party _____

Print Name and Relationship to Patient _____