VISION SOURCE™

DOUGLAS D. CREGER, OPTOMETRIST ~ JOHN E. CREGER, OPTOMETRIST

FINANCIAL POLICY

In order to reduce confusion and misunderstanding between patients and the practice, we have adopted the following financial policy. If you have any questions, please discuss them with our staff.

WE DO NOT PARTICIPATE IN ALL INSURANCE PLANS. IF YOU HAVE ANY QUESTIONS OR CONCERNS, PLEASE ASK.

FINANCIAL POLICY

* We may bill your insurance. In the event that you have no insurance, we accept VISA, Mastercard, American Express, Discover Card, CareCredit, checks, and cash.

* **Payment for examinations is collected on *day of service.*** Material costs are collected in full on day ordered, or 50% day ordered and the balance on the day materials are dispensed. A 5% savings is available for payments made in full on the day of service.You may receive a statement to file with your insurance company for fee reimbursement.

* Insurance is a method of reimbursing the patient, not a substitute for payment. A service charge will apply to accounts with an outstanding balance. A billing agency will be used for all accounts that have had no activity for 90 days, and $15 fee will be charged to your account for the use of this billing agency.

* We may bill third party liability insurance carriers once as a courtesy if complete information is provided at the time of service. If the balance is not paid within 60 days it is the responsibility of the patient.

* Some insurance plans require pre-authorization for services in order to be paid. It is the patient's responsibility to verify and obtain pre-authorization prior to services being rendered.

* Your insurance policy is a contract between you and your insurance company. As a courtesy we will file your insurance claim if you assign benefits to our facility. In other words, you agree to have your insurance company pay Dr. Creger directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive payment from your insurance carrier, we will refund any overpayment greater than $ 15.00 to you or leave the credit on your account. Please let us know your preference.

* We have contracts with several carriers and will bill them directly. You

will receive a bill for any balance due when we receive payment or denial from your company. The balance is due within 30 days of the insurance carrier's payment.

* Dr.s Creger will accept patients as Medicaid if proof of coverage is presented at time of service.

* All health plans are not the same and do not cover the same services. In the event that your insurance determines a service to be "not covered" you will be responsible for the complete charge. Payment is due within 30 days of denial.

* For all services provided to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment. We will not get involved in payment disputes between custodial and non -custodial parents.

* If you are unable to pay your account in full, please make financial arrangements prior to your appointment.

I have read and understand this financial policy. I understand that I am responsible for all charges incurred regardless of insurance or third party liability.

I authorize this office to release any information necessary to expedite insurance claims. I authorize payment of insurance benefits to Dr.s Creger for services provided. I authorize this office to release records to any physician that I may be referred to and any billing services for adjudication of claims. Permission is hereby granted to this office to obtain any medical records which are pertinent to this service. I hereby agree that the above information provided by me is accurate and correct.

x_____ _____ _____

Signature of patient Date Relationship (if other than patient)

_____

Signature of parent/guardian if signing for minor

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NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT

I acknowledge that I have reviewed the **Notice of Privacy Practices** which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree with the restrictions I request.

_____ _____

Signature of Patient or Legal Representative Witness

_____ _____

Date Date

RELEASE OF INFORMATION

I authorize you to release my health information to the following people:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____