FINANCIAL POLICY

Please initial where indicated

- *It is the patient's responsibility to know their coverage and eligibility; including the deductible.* _____
- Please present your insurance card(s) so we may make copies for your file. Insurance company information not given at the time of service may result in us not being able to bill your claim. _____
- It is the patient's responsibility to let the office know if you want a service billed as routine or medical at the time of service. There may be times when the reason for your service may warrant a medical visit when you feel you are actually here for routine services. _____
- **Please note that the patient is ultimately responsible for all balances, even those billed to insurance.** We bill insurance as a courtesy for our patients. We do our best to collect payment from insurance companies that we are providers for, but there are situations when the person who pays the insurance premium can get better and faster results from the insurance companies than the provider. _____
- **It is the patient's responsibility to get referrals from their Primary Care Physician or preauthorization from their insurance prior to services.** The Primary Care Physicians want to hear directly from the patient before outside appointments are made. Many managed care plans **do not backdate referrals**. Patients will be billed privately for any service when there is no referral on file at the time of service. _____
- **Copays are always due at time of service.** _____
- **Private pay services are always due at the time of service.** _____
- In the case of a minor, please be aware that the parent or guardian who brings the child for treatment is ultimately responsible for the child's account balance. Minors will not be treated unless an adult is present. ____
- If your insurance requires a specific form, please provide that at the time of service with the patient and employee information completed and signed.
- Our office accepts cash, personal checks, debit cards, Visa, MasterCard, AMEX, and Discover credit cards.

_____ _____

Patient/Guarantor Signature Date

CANCELLATION & RESCHEDULING POLICY

- Our schedule is carefully planned so the doctors can give you focused attention. Our office is happy to send out reminders via postcard and phone call.
- It is the patient's responsibility to notify us of an appointment cancellation or reschedule **within 24 hours** of your scheduled appointment so that we can meet the needs of other patients.
- Same day cancellations or rescheduled appointments will be considered a no show.
- We reserve the right to terminate our relationship as a result of repeated missed appointments, reschedules or late cancellations.

_____ _____

Patient/Guarantor Signature Date

CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

I authorize Silverdale Eye MDs, PS to use and disclose the health and medical information of

_____ for the purposes of Treatment, Payment, and Health Care Operations.
(Name of patient)

Treatment (includes activities performed by a physician, nurse, office staff and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers our practice by telephone as the on-call physician).

Payment (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, precertification and preauthorization).

Health Care Operations (includes the necessary administrative and business functions of our office).

You may review Silverdale Eye MDs, PS "Notice of Privacy Practices" for additional information about the issues and disclosures of information described in this CONSENT prior to signing this CONSENT. Please verify that you have received a copy of our Notice by placing your initials here _____.

Because we have the reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. You may request a copy to review at any visit or by calling our office between visits.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. **We are not required to agree to your request.** If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

I understand that I have the right to revoke this CONSENT provided that I do so in writing, except to the extent that Silverdale Eye MDs, PS has already used or disclosed the information in reliance on this CONSENT.

_____ _____ (or)
Date Signature of patient

_____ _____
Date Signature of person authorized by law