Welcome to Our Office

Financial Assignment, Agreement and Acknowledgment

The mission of Midwest Eye, PC. is to provide exceptional eye care services, products and knowledge to our patients in a comfortable, professional environment through our highly skilled, educated and caring staff.

Please read the following carefully, sign and date.

1. I understand and agree that payment is expected to be paid at the conclusion of each visit unless Midwest Eye participates in my insurance or other arrangements have been made prior to my visit.

2. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to Midwest Eye for any billable services furnished. I authorize Midwest Eye to release medical information about me to the health care financing administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.

3. I understand I am responsible for providing all accurate insurance information, driver's license and or state ID to Midwest Eye prior to all visits and that inaccurate or lack of information can forfeit benefits and billed to me for balance due upon receipt.

4. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hearby authorize said assignee to release all information necessary to secure the payment from insurance and I will be billed with payment due upon receipt. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance. For any out of network vision plans, Midwest Eye will supply paperwork for me to submit for reimbursement.

5. If Midwest Eye has not received a response from insurance within 60 days of submission, I will be billed for any balance due with payment due upon receipt.

6. If, during an examination, a medical diagnosis is found and is a condition that will need to be monitored and or treated, additional visits will be billed to any primary medical insurance with which we are participating providers for rather than an associated vision plan. All applicable specialist co-pays, deductibles, and coinsurance may apply. Your vision insurance can still be utilized for glasses or contact lenses as eligible.

7. I agree to work with the doctor to create a plan to monitor my eye health which may include treatments and/or procedures considered necessary by the doctor. I understand that, while the doctor will explain the testing and reason for testing, fees may not be discussed in the examination room. I understand that examinations are recommended on a yearly basis, but that, dependent on the diagnosis, I may be required to return more frequently to monitor my eye health.

8. If my account becomes assigned to a collection agency, I agree to pay all costs of collection, all agency fees, all court costs, and all attorney's fees as allowed by law.

9. I understand that there is a return check fee of $50. Return check fees are assessed on any bad/returned check including ACH payment plans. $50 will be assessed on each occurrence.

10. Your appointment time has been reserved just for you. If you cannot keep your appointment, we ask that you give us a minimum of two business days notice so that we may offer your time slot to someone in need. If that notice is not given there will be a $50.00 charge.

11. I understand that this serves as my signature on file for the duration that I am a patient with Midwest Eye, PC.

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Signature   Date   Printed Full Name

Vision Source

AUTHORIZATION FOR RELEASE OF
IDENTIFYING HEALTH INFORMATION

Tammy Twait, Privacy Official

Patient Name ____

Patient Address ____

Patient Phone Number _____________________________________

I have had explained to me prior to any services offered Midwest Eye's Notice of Privacy Practice and agree to continue my care with Midwest Eye under said terms.

I authorize Midwest Eye to release health information identifying me (including, if applicable, financial information, information about substance abuse, mental health conditions, genetic information, and HIV infection or AIDS) to the person or persons listed below:

Name and phone # of recipient:

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At times we may need to leave a message regarding glasses, contacts, billing questions or for you to contact our office. Please indicate the appropriate phone number below that you would like us to leave a message on.

____

Phone number

Upon signing this authorization, it may be revoked at any time by contacting in writing the Privacy Official noted at the top of this form. If changes are to be made it is your responsibility to notify the Privacy Official of those changes.

When health information is disclosed under this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

______________________________________ _________________

Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

____ ____________________________

Representative Relationship to Patient

Termination date for authorization: _________________ ________________________________

Date Signature