FLAGSTAFF EYE CARE FINANCIAL TERMS AND AGREEMENT

General consent to treat: By signing below, I authorize the health care providers at Flagstaff Eye Care, to conduct examinations, diagnostic tests and procedures to assess my health care conditions, and to provide care, services or therapies necessary to effectively diagnosis and treat me.

Medical consent to treatment: The Doctors at Flagstaff Eye Care are licensed to provide eye exams that are routine and/or medically based. Please be advised that should your routine exam change to a medical exam; your doctor will notify you at the time of service.

Consent to coordinate benefits: I understand that Flagstaff Eye Care accepts both vision and medical insurance plans. Vision plans cover routine eye exams and eyeglasses/contact lenses. All other billable services are usually sent to medical plans. By signing below, I authorize Flagstaff Eye Care to coordinate benefits and bill both my vision and medical insurance. I authorize release of medical information to my medical insurance and vision insurance as necessary to file and process my claim(s).

Receipt/Acknowledgement of HIPAA notice: I have read and understand Flagstaff Eye Care's policy of privacy practices. If you would like a copy of our HIPAA please ask.

Authorization to assign benefits and Statement of Financial Responsibility: I authorize and request that the payment of Medicare, any medical insurance and/or vision insurance benefits be made directly to Flagstaff Eye Care for any and all services provided to me by Flagstaff Eye Care. This also applies if coverage is provided by Medicare, a Health Maintenance Organization, a Worker's Compensation policy, or any other third-party payers. I understand that I will be responsible for all outstanding or unpaid charges.

I understand that if I DO NOT provide my insurance information at least ONE WEEK prior to the time of service, I will be solely responsible for all charges at the time of my appointment. Flagstaff Eye Care will not be able to bill my insurance after the fact.

Billing & Collections policy: I acknowledge that I am responsible for all charges for products and services provided by Flagstaff Eye Care, including any non-covered products and services or amounts not paid by my insurance. I understand that I will be billed for any outstanding balance not paid by my insurance companies. I agree to pay all outstanding balances within 30 days. **I agree to pay a $40 service fee for all balances not paid within 30 days.** I understand that Flagstaff Eye Care reserves the right to employ any 3rd party collections agency to collect outstanding balances over 30 days. I acknowledge that I am responsible for all collections fees assessed by Flagstaff Eye Care and their collections agent.

Eyewear and Contact Lens Policy: All Eyewear is custom fabricated to the wearers prescription and is not cancelable, returnable or refundable. Flagstaff Eye Care honors all manufacturers and laboratories warranty policies regarding normal wear and tear and manufacturers defects. I acknowledge that Flagstaff Eye Care is not responsible for and will not provide any warranty beyond that provided by the eyewear manufacturer or optical laboratory.

All contact lens services are non-refundable. I understand that contact lenses require separate and additional testing that's different from the eye exam and have additional fees that may not be included with my medical and vison insurance. All contact lens exam services include a follow up visit within 90 days. After 90 days from the time of service the patient will be responsible for any and all additional contact lens exam services. All custom-made contact lenses are non-returnable and non- refundable. All stock contact lenses that are unopened with undamaged are returnable within 30 days of purchase. Any opened or damaged boxes of contact lenses are non-returnable and non-refundable.

Print Name	Patient or Guardian Signature	Date