FINANCIAL POLICIES AND PATIENT RESPONSIBILITY

Bella Vista Eyecare Associates, PA does its best to accurately obtain your coverage and charge you in accordance to your insurance benefits. While we will do everything we can to keep you informed of covered vs. non-covered services (as quoted by your insurance company), final determination of coverage and payment is not made until our insurance claim is reviewed by your insurance company. By signing below, you understand that payment collected today is based on a quote from your insurance company and is not a guarantee of benefits. In cases where professional goods and services are not covered (therefore, denied) by your insurance company, it will be the patient's responsibility to pay for these services in full. Claims not paid due to errant or undisclosed insurance information provided by the patient will be the responsibility of the patient as well. If we are not on your insurance plan, we require full payment for all services and products at the time they are rendered, but will provide you with and itemized receipt that you may submit to your insurance plan for potential reimbursement.
I have read and understand the financial policy of Bella Vista Eyecare Associates and I do accept financial responsibility.

_______________________________________ _______________

(Signature of Responsible Party) (Date)

Vision vs. Medical Insurance and Assignment of Insurance Benefits

Vision insurance coverage is designed to cover routine eye services and to determine a glasses and/or contact lens prescription. When a medical condition or diagnosis is present, it may be necessary to file your examination with your medical insurance. Many times, we may not be aware of any medical diagnosis beforehand. These rules are often dictated by the insurance carriers themselves. Should this situation arise, we will do our best to inform you as to whether we will file your examination to your vision or medical insurance. In either case, the patient is responsible for any financial responsibility as dictated by their respective insurance company.
I authorize the payment of my medical/vision benefits to Bella Vista Eyecare Associates. I authorize Bella Vista Eyecare Associates to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

_______________________________________ _______________

(Signature of Responsible Party) (Date)

Minor Consent

By law, any child under 18 years of age cannot be seen by a doctor without consent from a parent or legal guardian. If a child arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

Name of individual who may act on Parent/Legal Guardian behalf:_______________________________

Signature of Parent/Legal Guardian:_______________________