Financial Arrangements & Health Insurance

Thank you for choosing Atchison Eyecare as your eye care provider. We are committed to providing the best eye care services possible and to help you understand our billing policy is a part of that process. The following statement explains our Financial Policy, which we ask you to read and sign. We are medical providers for many major insurances. It is your responsibility to verify your insurance coverage with your insurance carrier.

If you have a medical complaint, we will bill your medical insurance and not your routine vision insurance for your eye exam, therefore you will be liable to pay your medical co-pay for the exam. All other services we will bill toward your vision insurance if eligible.

Please note:

1. Services are rendered to the patient, not the insurance company. As a courtesy, our office will file your insurance if proper information is received. Please be advised that your insurance is a contract between you, your employer and the insurance company. Atchison Eyecare is not a party to that contract.

2. All applicable co-pays and non-covered services are due at the time of service.

3. Please be aware that some of the services provided may be non-covered services.

4. **While we will make every effort to verify and confirm your insurance benefits, it is your responsibility to understand the terms and conditions of your insurance plan.**

I have read and understand the above policy. I hereby accept the above policy and further agree that I shall be personally responsible for all co-payments, deductibles and non-covered services, as dictated by my insurance coverage.

Signature of Patient or Guardian: _____Date_____

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT.
We now offer the following payment options:

☐ **Payment by Cash**

☐ **Payment by Check (a $25.00 fee is applied to all bounced checks)**

☐ **Payment by Credit Card**

☐ **Guarantee any amount not covered by insurance with Visa or MasterCard**

Please make your choice, sign below and return to our office manager before treatment.

Our office is fully approved and an accredited user of the Visa and MasterCard Health Care Program, which will enable you to use your Visa and MasterCard to automatically cover amounts not paid by your insurance.

If none of the above apply, please see the office manager. Payments are expected at the time of service.

Printed Name: _____ Date: _____/_____/_____

Signature: _____

I, _____, have reviewed/received a copy of Atchison Eyecare's Notice of Privacy Practices.
Patient Name

I request that the below people be able to access my health information at Atchison Eyecare:

Printed Name: _____

Printed Name: _____

Signature of Patient or Guardian: _____ **Date:**_____