

**INSURANCE AUTHORIZATION AND BINDING FINANCIAL AGREEMENT**

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Northwest Eye Associates strives to provide the highest quality of eye care. Providing the best possible eye care involves a mutual understanding between patient and provider. Should you have any questions regarding the following policies, please ask for clarification. Our professional services are rendered to you, not your insurance company. Ultimately, payment for services is YOUR RESPONSIBILITY.

* Presentation of your health insurance card at each visit – It is necessary for us to verify your demographic & insurance information at each visit. If you forget your insurance card it may be necessary to reschedule your appointment or pay in full at time of service.
* Payment at time of service – ***Full payment is expected at the time services are rendered, including non-covered portions of insurance. This includes copays, deductibles, and services or materials not covered by insurance***. If you know you are unable to pay your copay/deductible, we may reschedule your appointment. Northwest Eye Associates makes considerable efforts to verify insurance coverage and benefits, however, we cannot guarantee the accuracy of the information provided. ***Financial responsibility is ultimately yours***.
* Payment of optical materials – A 50% down payment must be made for any glasses or contact lenses at the time they are ordered, with the remaining balance due at the time of pickup. Optical orders ***WILL NOT*** be dispensed without full payment.
* In the event that you receive payment from your insurance company for services provided in this office, you agree to endorse any received payment to the doctor's office.
* After your insurance carrier has determined your responsibility of our charges you will be billed. Your statement balance is due upon receipt. ***Failure to make payment or contact us during the billing cycle will result in your account being considered past due***. If attempts at payment are unsuccessful after 90 days, the account will be placed for collections.
* There is a $30 fee for all returned checks.

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* I authorize Northwest Eye Associates to release any information regarding my care to expedite claims or for records transfer should such events be required.
* I hereby authorize Northwest Eye Associates to bill my insurance company for services provided to me and with payment made directly to the providing doctor's office and that such authorization is valid until written notice is provided.
* I understand that I am personally responsible for any charges incurred at Northwest Eye Associates.

I understand and agree to all statements made herein and understand this is a legally binding agreement.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES**

By signing below you acknowledge that you have received a copy of Northwest Eye Associates' Notice of Privacy Practices. The privacy policy outlines how your information is shared only for the purpose of performing service or collecting payment.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_