2016 FINANCIAL POLICY STATEMENT AND PATIENT PRIVACY RIGHTS, PROTECTION & RESPONSIBILITIES AGREEMENT

1. All patients/guarantors must present their Driver's license or State ID at time of examination. For patients requesting we file services to insurance plans we participate in, a current medical insurance card must be presented at every visit to AEP. This information is required by all insurance companies in order to file claims.
2. All examination fees are due at the time of service. AEP doctors are participating providers in numerous vision and medical plans. AEP will file claims for services rendered to patients that participate in plans AEP is contracted with to accept assignment. AEP must follow all guidelines as outlined by insurance contracts. It is the patient's responsibility to pay all co-payments (medical and vision plan) at time of service as specified by their insurance.
3. If a patient presents as self-pay, payment in full is expected at time of service.
4. It is the patient's responsibility to pay all deductible fees, co-insurance, or non-covered service fees within thirty (30) days after insurance has processed the claim and determined the patient's responsibility. AEP's staff will send notice to the patient immediately upon receipt of the explanation of benefit.
5. **All eyewear and contact lens material fees must be paid in full before any orders are placed. Any co-payments for materials are due at the time of service**.
   Returned NSF checks will be charged a service fee of $30.00.
6. **AEP accepts cash, debit cards, personal checks, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, and CARE CREDIT.**

I HEREBY AUTHORIZE MY INSURANCE CARRIER TO MAKE PAYMENT DIRECTLY TO ADVANCED EYE CARE PROFESSIONALS, P.C. FOR ANY AND ALL SERVICES RENDERED TO ME BY ADVANCED EYE CARE PROFESSIONALS, P.C. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE.

I also release any information regarding my treatment or condition in order to obtain payment for the doctor's professional services.

HIPAA

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, obtain payment from third-party payers, and conduct normal healthcare operation such as quality assessments and physician certifications.

I acknowledge that I have received a copy of Advanced Eye Care Professional, P.C's Notice of Privacy Practices.

AGREEMENT

____________________	____________________	____________________
Date of Signing	Guarantor/Patient Signature	Witness
	____________________	
	Print Name	

REFUSAL OF SERVICE

I am not willing to be financially responsible; therefore, I am refusing service.

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Date of Signing	Guarantor/Patient Signature	Witness