

## 9. PAYMENT & FINANCIAL POLICY

**Thank you for choosing us as your primary eye care provider. We are committed to providing you with highly competent, conscientious, quality eye care. This policy is intended to provide information regarding patient and insurance responsibility for services rendered. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.**

- 1 Insurance.** We participate in some insurance plans, including Medicare, Tricare and Aetna. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card or insurance plan, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
- 2 Co-Payments and Deductibles.** All co-payments, cost shares and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, cost shares, and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
- 3 Non-Covered Services.** Please be aware that some and perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. Reimbursement is subject to the terms of your insurance contract.
- 4 Proof of Insurance.** All patients must complete our patient registration, information and policy forms before seeing the doctor. We must obtain a copy of your Driver's license and valid insurance card(s) to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
- 5 Claims Submission.** We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
- 6 Coverage Changes.** If your insurance changes or you add insurance, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 30 days from the date of submission, the balance will automatically be billed to you.
- 7 Nonpayment.** If your account is over 10 days past due, you will be charged a \$25 late fee. Partial payments will not be accepted. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. In addition to the amount owed, you will be responsible for the fee charged by the collection agency for costs of collections. Late payments will accrue late charges of \$30 per month on outstanding balances.
- 8 Missed Appointments.** Our policy is to charge \$30 for missed appointments not canceled or rescheduled within a reasonable amount of time (8 hours prior to appointment). These charges will be your responsibility and billed directly to you. Please help us to serve you better and other patients, by keeping your regularly scheduled appointments.

**Our practice is committed to providing the best treatment and service to our patients. Our prices are representative of the quality and effectiveness of the care being provided. Thank you for understanding our payment and financial policy. Please let us know if you have any questions or concerns.**

**I have read and understand the payment and financial policy and agree to abide by its guidelines:**

X \_\_\_\_\_ / /  
Signature of Patient or Responsible Party      Print Name      Date



8160 Freedom Lane NE | Suite D | Lacey, WA 98516

## 1. PATIENT INFORMATION

Patient Full Name: \_\_\_\_\_  
Street / Mailing Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Patient Email Address: \_\_\_\_\_  
Patient SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Patient Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Home Phone: ( \_\_\_\_ ) \_\_\_\_\_ Cellular / Work Phone: ( \_\_\_\_ ) \_\_\_\_\_

## 2. SPONSOR/INSURANCE INFORMATION

Insurance Company Name(s): \_\_\_\_\_  
Member / Subscriber Name: \_\_\_\_\_  
Sponsor / Subscriber SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Sponsor / Subscriber Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Insurance Identification #: \_\_\_\_\_ Prefix: \_\_\_\_\_ Suffix: \_\_\_\_\_  
Insurance Group #: \_\_\_\_\_ Sponsor / Subscriber Employer: \_\_\_\_\_  
Sponsor / Subscriber Relationship to Patient: \_\_\_\_\_  
List ALL Other Insurance - Medical and Vision Plans: \_\_\_\_\_

## 3. ASSIGNMENT, RELEASE & AUTHORIZATION TO TREAT

**I, the undersigned certify that I (or my dependent) have insurance coverage with TRICARE, MEDICARE or \_\_\_\_\_ and assign directly to Nico Rouse Corporation, P.S., d/b/a Dr. Rouse Vision Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Rouse Vision Clinic to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I further authorize Dr. Rouse Vision Clinic to exercise its medical judgment in determining the level of service, and to perform any specific tests or procedures deemed necessary to provide the appropriate eye care.**

X \_\_\_\_\_ / /  
Responsible Party Signature      Relationship to Patient      Date

#### 4. MEDICARE / MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare, Medigap or other secondary insurance Benefits be made on my behalf to Dr. Rouse Vision Clinic for any services furnished to me by Dr. Rouse Vision Clinic. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents, Medigap insurer, and other insurer any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for the deductible, coinsurance, or the 20% Medicare does not pay, and for any non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. My signature below further verifies that I have not joined an HMO or other entity in which my Medicare benefits have been relinquished.

X \_\_\_\_\_ / /  
Signature of Beneficiary Date

#### 5. NON-COVERED SERVICES BY MEDICARE

Medicare will not pay for a refraction (CPT Code 92015) because it is always a non-covered service. This service will cost you \$30 on the date of service.

#### 6. ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of the ROUSE EyeCARE CENTER Notice of Privacy Practices.

X \_\_\_\_\_  
Patient / Parent / Guardian - Name (please print)

X \_\_\_\_\_ / /  
Responsible Party Signature Date

#### 7. FAMILY and FRIENDS AUTHORIZATION

I understand that my healthcare information at Rouse EyeCare Center is protected and I have received a copy of their Notice of Privacy Practices.

The name(s) listed below are family members or friends to whom I wish to grant access to my healthcare information. I will rely on the professional judgment of my provider and his/her designee to share such information as they deem necessary.

I understand that information is limited to verbal discussions and that no paper copies of my protected health information will be provided without my signature on a Release of Information form.

I understand that some information is considered "sensitive." I understand that I must check the specific boxes below in order for my provider or his/her designee to release any "sensitive" information.

- Mental Health / Psychiatric Disorders (including depression)\*
- Chemical Dependency (drug and/or alcohol abuse/treatment)\*
- HIV / AIDS Virus\*
- Sexually Transmitted Diseases\*

\*A minor patient's signature is required in order to release information concerning care for: **1)** condition's relating to the minor's sexuality including, but not limited to: contraception, pregnancy and sexually transmitted diseases (age 14 and above); **2)** Alcohol and/or drug abuse (age 13 and above); and **3)** Mental health conditions (age 13 and above). This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it any time. It will be my responsibility to keep this information up to date as I recognize that relationships and friendships may change over time.

Name	Relationship
1. _____	_____
2. _____	_____
3. _____	_____

#### EMERGENCY CONTACT INFORMATION

Name (contact): \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone Number(s): ( ) \_\_\_\_\_  Home  Work  Mobile  
Phone Number(s): ( ) \_\_\_\_\_  Home  Work  Mobile  
Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

X \_\_\_\_\_ / /  
Patient Signature Date

#### 8. CONTACT LENS INSTRUCTIONS

I understand that contact lenses are a medical device regulated by the U.S. Food and Drug Administration, with a limited life-span. Like any medical device, proper care is necessary for successful wear and good health. Follow-up visits with the doctor are to insure that my lenses fit well and are not harming my eyes, and failure to return for these visits can threaten my vision and the health of my eyes. I understand that my doctor recommends yearly eye examinations for any person wearing contact lenses. Follow-ups are scheduled upon the doctor's recommendation. I am also aware that the prescription for contact lenses expires after one year. I agree to stop wearing my contact lenses and seek professional help if I notice: redness, eye pain, irritation or discomfort, decreased vision, excessive light sensitivity, eye lids matted or stuck shut together, or if I suspect anything is wrong. I have also been informed of the necessity of follow-up care to monitor my eye health. I understand that use of such a medical device presents risk of possible infection, mechanical injury and/or edema of the eye.

Patient Name (Printed): \_\_\_\_\_  
Signature (If Minor – Parent or Guardian): \_\_\_\_\_  
Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Dispenser / Staff: \_\_\_\_\_