Patient Name (Printed): _____

SECTION 1 ASSIGNMENT OF BENEFITS AND FINANCIAL POLICY

The patient/guarantor assigns all the insurance and/or Medicare benefits directly to the Yankee Eye Clinic and authorizes the release of all necessary information to file and complete the insurance claim(s).

- *I understand that* I am financially responsible for payment of all charges, whether or not paid by insurance, including any charges for services rendered which are denied, not prior authorized, or for any reason not covered by the applicable insurance company. This may include co-payments and deductibles not covered by my insurance.

- *It is your responsibility* to give us accurate and updated information for all of your insurance plans at each visit. Failure to do so may result in you being responsible for a balance that your insurance company may have otherwise paid. It is important for you to respond to your insurance company when any information is requested from you. Some insurance companies will not process your claim until you respond.

- ***Payment in full is required without proof of insurance***

- *Payment Terms and Conditions:* All balances are due in full within 60 days, regardless of pending insurance claims. If you believe you need more than 60 days to pay your charges, please make arrangements with our billing office.

- *Other Charges:* Unpaid balances older than 30 days may be subject to a monthly finance charge of 2.5% per month. Returned checks may be electronically presented to your bank with a $30 returned check fee.

- *Referrals/Disputes:* If for any reason I dispute the payments made by my insurance company, it is my responsibility to contact my insurance company for explanation. If a referral from my primary care clinic is required, and I choose to be seen without it, I agree to be responsible for the charges incurred if my insurance company refuses to pay.

- *Return/Refund Policy:* I understand that every pair of eyewear produced by Yankee Eye Clinic, Rosemount Eye Clinic and Cannon Eye Clinic is custom made to each patient's needs. For this reason, Yankee Eye Clinic, Rosemount Eye Clinic and Cannon Eye Clinic cannot accept returns except in very rare circumstances. In the event that I may receive a refund, I will be charged a restocking fee of 30%. In the event that I choose to restyle to a different frame or lens design (including progressive lenses, multi-focals or single vision lenses), I will need to pay for any extra cost. In the event that I choose a less expensive frame or lens design, fees may be retained by Yankee Eye Clinic, Rosemount Eye Clinic and Cannon Eye Clinic.

Patient's signature: _____ Date: ___/___/_____

OR legally authorized representative's signature _____ Date: ___/___/_____

Printed Name: _____ Relationship to patient: _____

SECTION 2 ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that Yankee Eye Clinic make every effort to inform you of your rights related to your personal health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment, if you wish.

Patient's signature: _____ Date: _____/_____/

OR legally authorized representative's signature _____ Date: _____/_____/

Printed Name: _____ Relationship to patient: _____