CLASSIC OPTICAL

FINANCIAL AGREEMENT & OFFICE POLICIES

We are very happy you have chosen CLASSIC OPTICAL to provide for all your vision care needs. We understand that many of our patients have insurance coverage through a medical and/or routine vision policy or discount plan. We are happy to submit an insurance claim on your behalf for services, treatment, or materials you seek from us. We will do all we reasonably can to provide sufficient information to your insurance carrier to obtain payment for your doctors fees, and or visual materials you order. **However, in the event your insurance company or companies refuse payment or issue reduced payment for materials or services for any reason, you agree to make immediate payment for any remaining or outstanding balances on your account**. **We remind our patients that it is the sole responsibility of the patient and/or patient's financially responsible party to know and understand their insurance benefits in full, prior to seeking exam services, treatment(s), or any materials from CLASSIC OPTICAL.**

You will be asked to update your personal and insurance information periodically, including providing our office with your full social security number (SSN), billing address, current phone numbers, as well as current copies of your medical and vision insurance cards (when provided to you by your insurance company). We are required by law, including the national *Health Insurance Portability and Accountability Act* (HIPAA) of 1996, to obtain your signature for permission to release protected health information to your insurance carrier for all payment of claims. We are also required by law to maintain strict confidentiality of your personally identifiable medical information. Thank you for assisting us in completing all required information in accordance with your insurance requirements and federal law.

In accordance with federal truth and lending laws, be advised that the following policies are in effect at CLASSIC OPTICAL, and that in seeking any exam services, treatment, or materials from our office you fully agree to be legally bound by the following:

- **In order to keep fees as low as possible, PAYMENT IS DUE IN FULL at the time exam services, treatment, or materials are rendered and/or ordered, including all co-payments required by your medical or vision insurance plan guidelines.**
- **Classic Optical accepts the following forms of payment: *Cash, Personal Check, Visa, Master Card, American Express*. We are also happy to offer our patients interest free payment options through *Care Credit.***
- **Any service or treatment requiring Doctor's time is non-refundable, with FULL PAYMENT IS DUE when treatment is rendered.**
- **Some medically necessary ophthalmic treatments may require MULTIPLE visits, with a separate co payment required at EACH visit. This is in compliance with your insurance company's specialist policy terms.**
- **All spectacle orders are completely customized for each patient. Once an order for spectacles has been placed, it is FINAL and CANNOT be cancelled, and any fees collected, including insurance co-payments are NOT refundable.**
- **Contact lens boxes that have been opened, written upon, are expired, or otherwise altered from their original state are not eligible for exchange. Contact lenses cannot be returned for refund.**
- **A minimum $50.00 charge will be assessed against your account for which any payment made that is reversed or returned for insufficient funds or any other reason or cause. This will be added to all collections or legal costs required to secure payment.**
- **I allow the undersigned signature to be held on file for release of all protected health information, insurance billing claims, and/or telephone credit card payments made on my behalf.**

MY SIGNATURE BELOW INDICATES I HAVE READ, UNDERSTAND AND FULLY AGREE TO ABIDE BY ALL OF THE FINANCIAL AND OFFICE POLICIES OF CLASSIC OPTICAL. I hereby authorize direct payment through my insurance benefits to CLASSIC OPTICAL. I further understand and agree that I am personally and ultimately responsible to pay all charges incurred and that any insurance claims filed on my behalf are a courtesy, with no guarantee of final payment. I further authorize CLASSIC OPTICAL to release any medical or personal information as required for direct treatment, medical referral, or payment of insurance benefits, and agree to hold this office free of any or all liability related to the release of this information in accordance with HIPAA and federal law:

PATIENT NAME (Please PRINT)____

SIGNATURE____ **Date**____________________

(Patient, Parent, Legal Guardian, or Legally Authorized Agent of Patient)

Q12012