Family Eye Care OF THE CAROLINAS

FINANCIAL RESPONSIBILITY AND PRIVACY NOTICE

Payment is expected at time of service for any co-pay, co-insurance, deductible and non-covered services.
We accept cash, check, money order, MasterCard, Visa, Discover or American Express.

The person who is present with the minor patient is financially responsible for date of service.

If health plan requires a preauthorization or referral the patient must obtain such BEFORE services are received.

There is a $20 billing administration fee for non-payment at time of service.

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that I am financially responsible and consent to serve as a guarantor of payment for all services rendered to the patient listed. Family Eye Care of the Carolinas (FECC) does not bill third parties for co-payments and non-covered services. When a minor is presented for care, the person present with minor is responsible for payment at time of service.

I understand the services provided by FECC may or may not be covered by my health plan. If my health plan requires a preauthorization or referral it is my responsibility to ensure it is obtained BEFORE services are received. If my health plan deems these services are non-covered or not medically necessary, then I understand that I am financially responsible for any non-covered/non-medically necessary services and/or supplies provided.

Although FECC may file insurance claims as a courtesy, I understand that FECC cannot accept responsibility for collecting insurance payments or for negotiating a disputed claim. Insurance reimbursement is a contract between the patient and the insurance carrier. Insurance company's Usual, Customary and Reasonable (UCR) allowable are established without regard to FECC's cost and charge. I understand that I am responsible for the difference between the insurance payment and FECC charges except in circumstances where FECC has a contractual agreement with a health plan that prohibits such collection of payment from the patient and/or subscriber.

I understand, should this account be referred to an attorney or collection agency, attorney's fees and or collection expenses shall be payable by me in addition to any other amount due.

I understand that appointments missed or not cancelled with greater than 24 hours' notice will be subject to a $40 fee. This fee is the sole responsibility of the patient/guardian and not payable by insurance.

Print Patient Name: _____

(If a minor)Print Name of Parent/Legal Guardian: _____

I have read and agree to understand this policy _____ Date _____
Signature

AUTHORIZATION TO RELEASE INFORMATION ("DO YOU WANT US TO FILE YOUR INSURANCE?")

Authorization for your Insurance to pay benefits to Family Eye Care of the Carolinas must be agreed upon or you will be self-pay

I hereby authorize Family Eye Care of the Carolinas to release information required during my examination and treatment and hereby assign payment directly to the designated physician for my medical/surgical services provided.

I acknowledge Family Eye Care of the Carolinas participates in E-Prescribing and authorize the physician and/or staff to submit and transmit any prescription information via the electronic health system.

Signature of the patient or their legal guardian

_____

Date _____

NOTICE OF PRIVACY ACT – HIPAA
("WHO CAN ACCESS INFORMATION AND/OR ACCOMPANY A CHILD?")

My signature below indicates that I have reviewed Family Eye Care of the Carolinas Notice of Privacy Practices. (available at front desk and www.feccweb.com) I also agree to allow the physician or a member of their staff to identify me by name in the lobby of this practice and also to contact any of the telephone numbers given to confirm appointment or deliver medical information.

Signature of the patient or their legal guardian

_____ Date _____

Anyone other than the individual patient or their birth parents, Primary Care doctor or referring doctor allowed to receive your Personal Protected Health Information must be listed below, or information cannot be shared. This includes step-parents, spouses, extended family and caretakers who may accompany patient to an exam. These are NOT emergency contacts. *(Limit 4)*

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____