Reveal Eye Care & Surgery Payment Agreement v1.03 revised 7/28/2016

3613 Williams Dr, Suite 703, Georgetown, TX 78628 Phone (512) 686-1224 Fax (512) 686-1272

It is the goal of our practice to maintain transparency with everything we do, and this includes our financial policy. With those factors in mind, you grant us permission to bill all claims of all visits for both procedures and exams to your insurance company. Patients that are self pay and patients with insurance companies that we do not have a contract will be required to pay in full on the day of service. We will provide you the information to bill your insurance company in that situation. All co pays, unmet deductibles, non-covered services are due on the day of service. You also understand that you may be billed by a lab or other 3rd party accounts for services provided at **Reveal Eye Care & Surgery**, and it is your responsibility to make sure the lab that is used is covered by your insurance. We accept payment with cash, check, and most credit cards. We will do our best to help arrange **Referrals and Pre-authorizations**, but it is your ultimate responsibility to make sure these are valid before your appointment. We will have to reschedule appointments without valid referrals or pre-authorizations when required. We will also charge a **$50** fee for each **returned check**. Patient accounts may be turned over to a collection agency if they are past due, and the balance due increased by an amount equal to the collection agency commission. If you choose to leave a credit card on file, we will automatically bill the credit card when the payment is due. In order to make sure that all patients can have access to be seen, patients who cancel within 24 hours or no-show may be charged a **$50** fee. Our office then reserves the right to maintain a credit card on file to schedule additional appointments. We also charge **$15** for form completion by physician or staff (FMLA, etc).

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Patient Initials

Refraction Policy In addition to the medical eye evaluation, refraction is the process of determining if there is a need for corrective eyeglasses. It is needed to write a prescription for glasses, and often to rule out certain eye problems. It is NOT a covered service by Medicare or most medical insurance plans. These plans consider refraction a “vision” service, not a “medical” service (our office does not take vision insurance). Our office fee for refraction is **$35**, and we ask that you pay for the refraction at the time of service. The refraction fee is charged regardless of giving a prescription for glasses and is good for a year. If you choose not to have a refraction performed you will not be able to receive a new eyeglass prescription. If you want a prescription later, you will need to return to the office to have a refraction.

Acknowledgement I have read the above information and understand that the refraction may be a non-covered service. I accept full financial responsibility for the cost of this service. The co-payment is separate from and not included in the refraction fee, and a contact lens exam is an additional fee.

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Patient Initials

Notice of Privacy Practices: I have been given the opportunity to review the notice of privacy practices, and provided a copy as desired.

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Patient Initials

Electronic Medical Record Communication If you provide your email address, we will send email appointment reminders, and an invitation to our patient portal where you can securely communicate with the practice, and review your medical information from our visit. We will also look up your medications directly from participating pharmacies improving our ability to verify your medications, and we send prescriptions electronically to the pharmacy. By initialing next to this section you acknowledge and agree to these procedures.

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Patient Initials

ACKNOWLEDGEMENT I have both read and understand the above agreements. I also have had adequate opportunity for questions, and I agree to the above terms. I agree that I will complete my obligations with **Reveal Eye Care & Surgery** under the agreement. I understand that I am responsible for any and all amounts of my bill that are not reimbursed by the insurance company, and I assign directly to **Reveal Eye Care & Surgery** all insurance benefits otherwise payable to me for services rendered (including Medicare, private insurance plans, etc). I hereby authorize the doctor to release all information necessary to secure the payment of benefits, and I authorize the use of this signature on all insurance submissions.

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Patient Signature Printed Name Date