Patient Name: _____

DOB: _____

Mountain View Eye Care Financial and Privacy Policy

Full payment for service(s) is due at the time of service(s). We accept cash, checks, Visa, MasterCard, and Discover.

ϖ I request payment of authorized Medicare and/or insurance benefits be made on my behalf to Mountain View Eye Care for any services furnished by them. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, its agents, or any other insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing.

ϖ I understand I am financially responsible for all charges not covered by my insurance, and all copays and deductibles are due at the time of service. I also understand an additional fee of $25.00 will be charged for all returned checks.

ϖ Medicare and most medical insurances do not pay for the refraction which is how the doctor determines your best visual acuity and is often performed to write a prescription for glasses and contacts. We are required to charge separately for this portion of your exam. If you have a routine vision plan, it may cover the cost of the refraction, and we will bill it when possible. I understand my insurance may not cover the refraction, and I agree to be fully responsible for the fee of $15.00.

ϖ If my health insurance requires prior approval or a referral for services, I understand it is my responsibility to obtain it prior to the day of my appointment. If the referral is not received by Mountain View Eye Care, I understand my appointment may be cancelled until such time it is received, or I will be responsible for any fees associated with the office visit.

ϖ A routine eye exam that can be billed to a vision insurance plan covers a prescription to address the following vision conditions: Near-Sightedness, Far-Sightedness, Astigmatism, and Presbyopia. All other causes of decreased vision, may be billed medically after discussing them with your doctor and may result in higher fees.

ϖ I understand a legal guardian MUST accompany minors at their initial visit and an adult at all subsequent visits. The legal guardian is responsible for full payment of services at the time of treatment.

ϖ This office is not a party to your divorce decree. The legal guardian who accompanies the minor at the initial visit is responsible for payment.

ϖ I authorize Mountain View Eye Care to communicate with me by phone, answering machine, letter, or email at my home or business regarding appointments, care, or billing.

ϖ I agree to the release of my medical information to my optometrist.

ϖ I give permission to discuss my medical information with the specific individuals named below (examples: spouse, adult children, caregiver, emergency contact). I understand it is my responsibility to update this list in order to keep accurate those authorized persons to receive or use my healthcare information.

1. _____ 2. _____

3. _____ 4. _____

ϖ I acknowledge a copy of Mountain View Eye Care's Notice of Privacy Practices is available for my review and a copy will be provided at my request.

Signature (Patient/Legal Guardian): _____ Date: _____