SOUTHSIDE EYE CARE
PROFESSIONAL EYE CARE & SURGERY

Southside Eye Care Financial and Practice Policies

FINANCIAL RESPONSIBILITY

Thank you for allowing us to serve your eye health and vision needs. We are committed to providing the best possible care to our patients in addition to timely and courteous service. All professional services rendered, require payment in full at the time of service, unless other arrangements have been made in advance with the billing department. This includes all copays, deductibles, co-insurance, refraction fees and any other non-covered service fees due.

As a courtesy to our patients, we will file insurance claims on your behalf to your insurance carrier(s). To ensure proper submission, we request you provide current insurance information to us on your Patient Information Form. All necessary information must be completed to file for insurance carrier payments.

ACKNOWLEDGEMENTS:

Your signature on this document indicates your understanding and agreement with the following:

- **You agree to provide all requested information and agree to pay a $50.00 fee for any returned checks.**
- **You acknowledge you will be charged a $50.00 fee for failure to show for a scheduled appointment.**
- **You accept responsibility for payment of your account balance and should your account become delinquent you agree to be held accountable for your account balance, collection charges and/or attorney fees.**
- **You agree to provide this office a minimum of 24 hours advance notice should you choose to cancel or reschedule an in-office surgical procedure. You acknowledge that your account will be charged a $100.00 fee if a minimum of 24 hours is not provided.**
- **You authorize the doctors and staff of Southside Eye Care to perform any reasonable procedure required for a complete eye exam which may include an additional $50.00 fee, should you require refraction.**

ASSIGNMENT OF BENEFITS

I, the undersigned, have requested medical/vision services from Southside Eye Care, PLLC on behalf of myself and/or my dependents, and understand by making this request I become fully financially responsible for any and all charges incurred in the course of the treatment authorized for me, regardless of what my insurance pays. I hereby authorize and direct my insurance carrier(s), including Medicare, to pay directly to Southside Eye Care, PLLC any benefits due under my insurance plan for me and/or my dependents. I understand I am responsible for any amount not covered by insurance and I agree to pay the balance of expenses not paid under this plan, including, but not limited to deductibles and co-payments. I authorize a photocopy of my signature be used to process insurance claims until I revoke this authorization in writing.

____ ________________________

Patient or legal authorized individual signature Date

Updated 8/6/2018

Southside Eye Care Financial and Practice Policies

AUTHORIZATION TO RELEASE INFORMATION

I understand that patient health information is private and confidential, and that Southside Eye Care, PLLC staff work hard to protect patient privacy and the confidentiality of personal health information.

I authorize the doctors and staff of Southside Eye Care, PLLC to use and disclose my and / or my dependents' personal health information to help provide needed health care, to handle billing and payment, and to take care of other health care operations.

I understand the doctors and staff of Southside Eye Care, PLLC have a document called "Notice of Privacy Practice" which contains more information about policies and practices protecting patient privacy. This Notice of Privacy Practice contains a complete description of my privacy and confidentiality rights. These rights include, but are not limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be made by specific methods. I understand I have a right to read and receive a copy of this Notice of Privacy Practice before signing this acknowledgement. I also understand it is my responsibility to familiarize with my insurance plan and benefits and in some cases to initiate pre-authorization or request a referral for care at Southside Eye Care.

I hereby authorize the doctors and staff of Southside Eye Care to perform any reasonable procedure required for a complete eye exam which may include an additional $50.00 fee, should I require refraction. (Refraction is a diagnostic test used to determine a patient's best visual acuity using a series of lenses to determine which prescription provides the sharpest/clearest vision.)

I have read and signed Southside Eye Care's Notice of Privacy Practices for Protected Health Information and I understand this authorizes my physician to release information necessary to process my insurance claims to my insurance carrier.

To the best of my knowledge, I've provided the most up-to-date information as applies to my record of health information, insurance and accounting.

______________________________ ______________________
Patient's Name (PRINT) Date of Birth

______________________________ ______________________
Patient or legal authorized individual (SIGNATURE) Date

____
Relationship to patient if signed by anyone other than patient

Name(s) of individuals we may release relevant information to regarding your care:

Name	Date of Birth	Relationship	Contact Phone #

Name / Date of Birth / Relationship / Contact Phone #

Updated 8/6/2018

Southside Eye Care / 3206 Churchland Blvd. / Chesapeake, VA 23321 / Tel (757) 484-0101 Fax (757) 484-0515