FRONT RANGE EYE PHYSICIANS
FINANCIAL POLICY

Thank you for choosing Front Range Eye Physicians and Front Range Optical for your eye care needs. We pledge to you the best treatment and service possible, and we also believe that good care for you and your family starts with good communication. We have created this policy to help you understand your responsibilities for payment of our fees, which is necessary in order for us to maintain our high standard of care. If at any time you have questions or concerns with our fees or payment process, please don't hesitate to talk to Lisa, our billing supervisor.

Payment for our services is due at the time that those services are provided to you, and we expect that all charges we present to you at a visit will be paid at the time of the visit. This includes, among other items, co-pay amounts, program deductibles, earlier charges that remain unpaid, and charges for services that we believe are not covered by, or which remain after coverage by, insurance or government programs. We may send you statements and reminders of charges that we believe remain to be paid, or may call you about the same. By accepting our services, you are consenting to receive these communications and to make payments in a timely manner.

We require that our patients promptly pay all charges that we present to them. In some cases, our fees may be adjusted, based on whether we participate in or accept insurance or government program payments, allowances, or limitations. But, if we present a charge to you, it means that we have taken any such adjustment into account and that you must still pay the amount remaining. If you are reimbursed directly by a program for the cost of your care, you must still pay our charges promptly, whether or not you have received that reimbursement.

If you do not agree with patient responsibility amounts or reimbursement amounts set by your insurance or government program, that is a matter between you and that program. We are happy to provide you with factual information about your care and billing to help you discuss this with them, but we still require you to promptly pay to us the entire charge we present to you, even if your issue with that program is not resolved.

The following is a list of some scenarios that may occur, and what you are responsible to pay in each:

- If your payment check is returned to us for lack of funds, you will be responsible both to pay us promptly with another form of payment, and to repay us the bank fee incurred.
- A refraction may or may not be covered by your insurance as part of your eye examination. If it is not covered by your insurance, you are responsible to pay the refraction fee.
- By the same token, some higher-cost or elective items also may or may not be covered by insurance. If they are not, you will be responsible to pay for them on the same day you are charged for them. Examples include laser vision correction surgery, toric intra-ocular lenses, and certain contact lens fittings and/or materials.
- If you do not have or choose not to use your insurance coverage, your self-pay charges must be paid on the day of the appointment.

AUTHORIZATION TO RELEASE INFORMATION

I authorize Front Range Eye Physicians, P.C. to release medical record information (pursuant to applicable federal and state laws, rules and regulations) to third party payers and other providers on my behalf or that of my family.
I further authorize any other individual or entity that has provided health care to me to release to Front Range Eye Physicians, P.C. any and all medical record information (whether in printed or electronic form) needed to provide me or my family with informed care. I may revoke my consent (in writing) for the release of this information at any time, except to the extent that action has already been taken in reliance on the consent.

ASSIGNMENT OF BENEFITS

I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to Front Range Eye Physicians, P.C., for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.

GUARANTEE OF PAYMENT

I agree to pay all applicable charges which are not paid in full by my insurance. If amounts due to Front Range Eye Physicians, P.C. are not paid according to this financial policy, my account shall be deemed delinquent. In the event that I default on payment of my account, I understand that I am responsible for any and all cost incurred on the collection of my account, including court costs and reasonable attorney's fees. If the debt is assigned to a third party collection agency, I agree to be responsible for collection fees and interest due for amounts in default.

WRITTEN ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby acknowledge that I have received and/or had an opportunity to ask questions concerning the Privacy Statement of Front Range Eye Physicians, P.C.

_____ _____

Patient's Signature **Date**

_____ _____

Responsible Party (if applicable) **Relationship to patient (if applicable)**