PROCARE VISION CENTER

Financial Agreement and E- Authorization

1. Financial Agreement: ProCare Vision Center will gladly submit your insurance for you and process it according to how your insurance company responds. **However, it is your responsibility to know and understand your insurance.** If you have questions regarding your coverage or the payment rendered by your insurance, you will need to call either your insurance company or your Human Resources Department. We cannot predetermine how your insurance will process your bill. **Co pays listed on your card will be required as payment for each service date.** If your card lists a specialist co pay or has required a previous co pay not listed on your card, you will be charged this amount. You are responsible for any part of the bill that your insurance does not cover. **If you do not have payment at the time of service, a $15 service fee will be attached to your account.**

We require a copy of any insurance cards you have at each date of service. If you do not bring your insurance card, we have the right to expect payment in full and bill your insurance later or to reschedule your appointment. If correct insurance is not provided at the time of service, we cannot make any monetary adjustments at a later date.

After your insurance has processed your claim, we will send you a billing statement. If no payment or payment arrangements have been made after the 2nd billing statement, a finance charge of 10% will be applied to the remaining balance. If you have not responded to billing statements or other requests for payment , we will apply the unpaid balance to your credit card. By signing this agreement, you hereby authorize Procare Vision Center to apply to your credit card any amount due and owed on your account. Credit card numbers are NOT kept on file. All services and warranties will be held. If the bill is submitted to a collection agency, you will be responsible for all collection fees and interest.

Any balance due of less than $5.00 will not be charged to you. Any refund due of less than$5.00 will be left as a credit on your account and forfeited after 1 year.

There will be a **$30 fee** for any check returned for insufficient funds. Payment due must be paid by cash or credit card. If you are owed a refund and paid by cash or check, we will refund the money to you by check after your check has cleared. If you paid by credit card, the money will be refunded to you on the same credit card.

When your glasses order has come in, we will notify you. If you have not picked up your glasses nor notified us 30 days after this notice, any amount you have paid as down payment on the glasses will be forfeited.

3. Authorization for ePrescribe: By signing this consent you agree to allow your healthcare provider to electronically transmit your prescriptions to and from the pharmacy you designate. You also consent to the disclosure or exchange of your prescription medication information to or from appropriate healthcare providers, pharmacies, insurers or prescription benefits companies, including any state or federal health program for the purpose of your treatment. _____ **CHECK HERE ONLY IF YOU DECLINE CONSENT**

4. Authorization for Health Information Exchange (HIE): Your healthcare provider may participate in HIE. An HIE provides the technology necessary for your healthcare provider to share appropriate elements of your care with other licensed healthcare providers to facilitate referral, diagnose and treatment for continuity of care. _____ **CHECK HERE ONLY IF YOU DECLINE CONSENT**

BY SIGNING BELOW INDICATES YOU HAVE READ, UNDERSTAND, AND AGREE TO COMPLY WITH OUR POLICIES.

_____

Print patient name Date of Birth

_____

Print second patient name (if applies) Date of Birth

_____

Signature Date

PLEASE LIST WITH WHOM WE MAY SHARE INFORMATION REGARDING YOUR EYE CARE:

Name_____ Relationship _____

PLEASE LIST YOUR EMERGENCY CONTACT:

Name_____ Phone Number: _____

PROCARE
VISION CENTER

Appointment Policy

An appointment scheduled in our office is reserved specifically for you with the doctor. **If you are unable to make your reserved time, we ask that you call our office at least 24 hours in advance. We have voicemail available for after hours messages.** A "No Show", "Cancel" or "Reschedule" appointment is when a patient fails to come in or call us with a 24 hour advance notice. Because we are aware that sometimes that is not possible due to an emergency, **each patient will be given 1 exception within a two year time period.** On the second No Show, Cancel or Reschedule without proper notice a fee of **$25.00 will be charged and must be paid before any other services or appointments will be scheduled.** We also reserve the right to not schedule future appointments for you or your family.

By signing this I recognize I have been notified of the Procare Appointment Policy.

_____
Print patient name

_____
Signature Date