Washington Pacific Eye Associates

134 Central Way, Kirkland WA 98033

Phone: 425.889.2020 | Fax: 425-739-0601

WWW.KIRKLANDEYE.COM

FINANCIAL POLICY

Thank you for choosing Washington Pacific Eye Associates for your eye care needs. This consent form and financial policy has been developed to assist in answering questions regarding patient and insurance responsibility for services rendered and products ordered at Washington Pacific Eye Associates. Please read the policy below and ask our staff any questions you may have, and sign in agreement as indicated.

Consent for Treatment: I authorize Washington Pacific Eye Associates to provide medical care to myself and/or my dependent.

Release of Medical Information: I authorize Washington Pacific Eye Associates to release necessary medical information to my insurance carrier, its agents, or third party payers in order to determine payable benefits for services rendered.

Insurance Policy: Your insurance policy is a contract between you and your insurance carrier. You are responsible for providing Washington Pacific Eye Associates with correct insurance information at the time of service. Washington Pacific Eye Associates may quote insurance benefits as a courtesy; however, an insurance benefit quote does not constitute a guarantee of payment from your insurance carrier. Should your insurance carrier fail to pay the insurance claim for services rendered or products ordered within 90 days of the claims submission, you will be responsible for the charges.

Travel Insurance Policy: Patients with Travel Insurance will be required to pay for services in full at the time of service. Often times Travel Insurance carriers can take over a year to pay claims and may not pay at all. Upon receipt of payment from the Travel Insurance carrier the patient will be reimbursed from Washington Pacific Eye Associates.

Financial Responsibility: I understand that I am financially responsible for services rendered and products ordered at Washington Pacific Eye Associates. I understand if I have insurance and have provided accurate and complete information regarding my insurance, my charges will be filed with my insurance carrier as a courtesy; however, I am ultimately responsible for full payment of all charges not covered by my insurance. If my insurance can't be verified at the time of service I will pay in full for all services.

Co-Payments, Deductibles and Co-Insurance: Patients are expected to pay co-payments and all amounts that are not covered by their insurance carrier at the time of service. Payments may be made by cash, check and/or credit card (American Express, Discover, MasterCard and Visa).

I understand that if I have a high deductible medical insurance plan ($\geq$ $1,000) and have not met my deductible for the year, a $100 deposit is due at the time of service. Once my insurance has been billed and processed any balance owed will be my responsibility.

Refractions: A refraction is the measurement of the focusing characteristic of an eye; it determines the set of lenses that will best focus the light entering the eye. The results of a refraction are used to: determine the health and visual potential of an eye (cataract surgery), aid in performing tests (visual fields) and to prescribe glasses and contact lenses.

Refractions are considered a non-medical service by most insurance carriers (Medicare) and therefore deemed a non-covered service. If your insurance carrier does not cover refractions, the fee is $80 and due at the time of service if performed as part of your care.

In the event a glasses prescription needs to be modified, Washington Pacific Eye Associates will provide one recheck within 90 days of the original refraction.

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Contact Lens Evaluation: To prescribe contact lenses, additional testing must be completed to evaluate the effect contact lenses have on your overall eye health. The contact lens evaluation is not part of a routine eye exam and most insurance carriers do not cover the cost of contact lens services. If your insurance carrier does not cover the cost you are responsible for paying the evaluation fee at the time of service. Please see Washington Pacific Eye Associates' Contact Lens Evaluation Policy for more detailed information.

Referrals: Patients may be required by their insurance carrier to obtain a referral from their Primary Care Physician authorizing the patient to receive care at Washington Pacific Eye Associates. It is the patient's responsibility to obtain this referral prior to their scheduled appointment with Washington Pacific Eye Associates. I understand if my insurance carrier does not pay my claim as a result of no referral, I am financially responsible for all charges submitted to my insurance carrier.

Open Balances: Patients with open balances from previous office visits or surgical procedures will be asked to pay their open balance in full at the time of their next visit. Patients who are experiencing difficulty in making payments on open balances are asked to contact the Billing Manager, Ashley Zeller (425)889-2020 Ext 4, to establish a fair and appropriate payment plan.

Returned Checks: There will be a $30 fee assessed to your account for any check returned to our office as unable to process from the bank.

Collection Fees: Patient accounts which have not been paid by the patient for more than 90 days after the first billing cycle may be referred to an outside collection agency. If my account is referred to a collection agency, I agree to pay all costs (attorney fees, collection agency fees, etc.) in addition the outstanding balance owed to Washington Pacific Eye Associates.

Missed Appointments: Washington Pacific Eye Associates tries hard to maintain our schedule so that all of our patients can be treated promptly. Cancelling with short notice, showing up late or simply not showing up is very disruptive for our schedule and unfair to our patients who value prompt treatment. I understand that if I miss an appointment or give less than 24 hours notice to cancel or reschedule an appointment a $50 missed appointment fee will be charged to my account.

I have read, understand and agree with the Financial Policy above as outlined above by Washington Pacific Eye Associates.

_____ Date:_____

Patient Signature (or patient representative if under 18)

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Patient Name (please print)