# Advanced Eye Care of Michigan

**No-Show/Cancellation Policy:**
Our office will charge a fee of $25.00 to your account for all "no-show" or cancellations in which the patient does not give our office the courtesy of at least 24 hour notice. The office requests that if you are unable to make your scheduled appointment, you call to reschedule. If it is after or before regular hours, please leave a message and we will return your call.

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*Initials

**Financial Agreement:**
All co-pays are to be paid at the time of service. If you are unable to fulfill your financial responsibility, we do reserve the right not to render services at the scheduled appointment. Our office accepts: cash, checks, money orders, Visa, MasterCard, Discover, and American Express. Outside financing is available thru Care Credit upon request and approval. Returned checks will be subject to a $30.00 returned check fee.

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*Initials

**Assignment of Benefits:**
Our office will accept assignment of benefits from your insurance company with the provisions listed below. It is important to understand that the agreement regarding your vision and medical benefits is between you, your employer and your insurance company. The following provisions identify our policies governing insurance claims.

- We will bill you insurance company as a courtesy with your consent signed below.
- We require you pay the estimated portion not covered by your insurance company at the time we provide service to you.
- Insurance is ordinarily received within 30-45 days from the time of billing. If you insurance company has not made payment to our office within 45 days, you will be responsible for the entire balance at that time. At that point you will be responsible to seeking reimbursement from your insurance company.
- We do not guarantee that your insurance company will pay for treatment received from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- We will not enter into a dispute with your insurance company over any claim, although we will provide the necessary documentation if your insurance company requests to sort out any confusion or questions that may arise. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I have read and accept the terms and conditions of this assignment of benefits agreement. I authorize my insurance company to pay my vision and/or medical benefits directly to: Advanced Eye Care of Michigan.

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*Initials

**HIPPA/Patient Privacy Act:**
The Health Insurance Portability and Accountability Act requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future. To comply with one of HIPPA's requirements, we are offering to give you a copy of our Notice of Privacy Practices. This policy contains information that HIPPA requires us to disclose regarding our privacy practices. We are also required to obtain your written consent and acknowledgement prior to disclosing any of your information, except for enforcement investigations, and to comply with government mandated reporting.
It may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult another doctor or health care professional , or make disclosures of your information in connection with providing or coordinating your treatment.

_____ _____
Patient Signature (Parent/Guardian if under 18) Date

**Please list any other person(s) that we may share your vision/medical information with:**

_____ _____
Name Relationship

_____ _____
Name Relationship