WELCOME TO ALL SAINTS EYE CENTER!

We believe it is important for our patients to fully understand our **Financial Policy.** Please review the Financial Policy carefully. To avoid any misunderstanding regarding this policy, it is necessary for you to read and sign below, **before** treatment is rendered. Please ask us any questions you may have regarding this document and take a copy home for future reference if necessary.

OUR FINANCIAL POLICY

This policy covers office visits, required tests and services performed at All Saints Eye Center's facility. By signing below, I am agreeing to the terms of this Financial Policy.

Medicare Patients: we are participating physicians with Medicare. This means you will be responsible for the 20% of the approved Medicare fee for covered services, the current yearly deductible (ie. **$147.00 in 2013)** and full payment of any non-covered services. Non-covered services include, exams, refractions and surgeries. We file Medicare as a courtesy to you, Medicare **may** forward the claim to your secondary insurance, we, however do not file to secondary insurance companies.

Payment is at the time of service: Payment is due in full at the time of services unless you are covered by Medicare or an insurance company with which we participate.

ACKNOWLEDGE OF NOTICE OF PRIVACY PRACTICES

I have been given the opportunity to review All Saints Eye Center's (ASEC) Notice of Privacy Practices (a separate document) prior to signing this acknowledgement. ASEC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our office.

I hereby acknowledge that ASEC may use and disclose my protected health information to carry out treatment, payment and healthcare operations. ASEC's Notice of Privacy Practices provides a complete description of such uses and disclosures. Uses and disclosures not listed in the Notice of Privacy Practices will require my prior written authorization.

I may make restrictions to the use and disclosure of my protected health information or revoke a previous request for restriction at any time except to the extent that the practice has already made disclosures in reliance upon my prior authorization to do so. Both Requests for Restriction and Revocations must be in writing. By signing below I am acknowledging that I have received ASEC's Notice of Privacy Practices and understand my rights to modify how my information is used and disclosed. If ASEC determines that my restrictions make it impossible for them to carryout my treatment, payment and healthcare operations they may refuse to accept me as a patient.

I agree to the Financial Policy and acknowledge that I received the Notice of Privacy Practices.

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Signature of Patient or Legal Guardian Date