ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of the following Eyes On High, LLC Policies:

1. Notice of Privacy Practices
2. Office Policies for Patients
3. Policy Regarding Vision Care and Medical Insurance

Patient name _____

Guardian/parent name (if under 18)_____

Signature_____Date _____

*Patients under 18 cannot sign, a parent or guardian must sign for them.

By signing above, I acknowledge the following:

1. I authorize Eyes On High, LLC to bill my vision and/or medical insurance (if a medical diagnosis exists) for services rendered. I understand that I may be responsible for services not covered by my insurance company.
2. I understand that all co-payments and payments for services not covered by insurance are due at the time of service.
3. I understand that professional fees are **not refundable.**
4. My health information will not be released to any person or entity without my written consent, as this is protected information. In the case of children, health information will only be released to a parent or guardian present at the time of the examination unless other instructions have been given to the staff doctors of Eyes On High, LLC.
5. It is also acknowledged that any unpaid balances may be subject to collections and is the responsibility of the guarantor.

The following individuals have my authorization to access my Protected Information:

Name:_____ **Relationship:**_____ **Date of Birth:**_____

Name:_____ **Relationship:**_____ **Date of Birth:**_____

Name:_____ **Relationship:**_____ **Date of Birth:**_____

Name:_____ **Relationship:**_____ **Date of Birth:**_____

Name:_____ **Relationship:**_____ **Date of Birth:**_____

Eyes On High, LLC
Drs. Bennett, Bennett, and Kloman,
Office Policies for All Patients

Payment for services is ultimately the responsibility of the patient and/or their responsible party if a minor. Vision insurance plans are designed to share in the cost of your vision care; it may not cover the total cost of your bill.

Patients with insurance

Patients with insurance are required to pay all applicable co-pays at the time of service. We will do our best to calculate your co-pay accurately. If we overestimate your charges, the excess will be credited to your account or a refund check will be issued. If we underestimate your charges, the remaining balance will be billed to you.

It is your responsibility to provide us with your most up to date insurance information.

Please note: if a particular service is not fully covered or is applied to your deductible, you will be responsible for the remainder of the fee. If a particular service is not covered at all, you will be responsible for the full fee. For any balance due, we accept Cash, Check, Visa, Mastercard, Discover, and American Express.

Well vision exams vs. medically necessary eye exams

VSP, EyeMed, and Superior Vision (Vision insurance plans) only cover "well vision" visits. That is, they do not cover services for medically necessary eye exams, such as exams for diabetes - those exams are covered by your medical carrier. The risks of eye complications are very high in patients with diabetes and so the examination by the doctor is more complex. These exams will be billed to medical insurance first and only to vision if no complications are detected and the medical carrier does not cover the cost of the exam.

Vision therapy visits, vision therapy assessments, and emergency visits are also medical services and not covered by vision plans. Please ask a staff member if you have questions regarding this policy.

Cancellation and no show policy

The appointment made is a time reserved especially for you. We require 24 hours' notice for cancellation of an appointment. There will be a $25 charge for patients who do not show for their appointment and do not call to cancel (No Call/No Show). Patients who No Call/No Show for more than 1appointment will not be permitted to schedule advance appointments. Patients who repeatedly cancel within 24 hours of their appointment will be asked to seek care elsewhere.

Returned check policy

There is a $35.00 service charge on all returned checks.

Outstanding balances

All accounts with an outstanding balance that is older than 60 days will incur finance charges of 18% APR or $5/month, whichever is higher.

I have read the above financial and cancellation policies and agree to abide by them. **I understand that I am financially responsible for all charges as well as providing the correct insurance information to Eyes On High, LLC.**