Eye Care Group of Southern Oregon, PC

☐ Grants Pass Office ☐ Cave Junction Office

Thank you for choosing the **EYE CARE GROUP!** Our goal is to provide you with the most complete and advanced primary eye care available. By combining state of the art technology with quality clinical care, we continually strive to fulfill your eye care needs and surpass your expectations. Our doctors and staff will strive to ensure a pleasant and caring experience. We look forward to serving you!

HEALTH INFORMATION ACKNOWLEDGEMENT & CONSENT

I understand that **EYE CARE GROUP** (referred to below as "This Practice") will use and disclose **health information** about me**.** I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnosis, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care;
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices will be posted in the reception area and available on This Practice's website at www.eyecaregroup.net.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

Please list the names of those individuals whom you authorize us to release your health information to: You may wish to list your primary care physician, spouse, family member or the like.

_____

_____

_____

_____

By signing below, I agree that I have reviewed and understand the information above and that I <u>have received</u> a copy of the Notice of Privacy Practices.

Signature: _____ Date: _____
(Patient)

OR

Patient Representative: _____ Description of Representative's Authority: _____

Scott M. Walters, OD
Daniel J. Vidlak, OD
Jeffrey S. Pelson, OD 1022 NW 6th Street Grants Pass, OR 97526 (541) 476-4545
James F. Adamek, OD 335 Caves Hwy Cave Junction, OR 97523 (541) 592-3921

EYE CARE GROUP
OF SOUTHERN OREGON, PC

Office Financial Policies

It is the office policy to inform you of our patient payment procedure. In this agreement the words "you" and "your" mean the patient/debtor. The word "account" means the account that has been established in the name to which charges are made and payments are credited. The words "we", "us" and "our" refer to Eye Care Group of Southern Oregon, PC. This document is available online at www.eyecaregroup.net.

We accept cash, check, Visa, Mastercard, Discover, Health Benefit Cards & Care Credit. There is a $25 charge for all returned checks per ORS 30.701. Ophthalmic purchases require 50% down prior to order, with the balance due upon delivery.

Payments & Finance Charges:
The total amount owing at the close of any billing period is due and payable in full prior to closing date of the next following billing period. If you choose to pay less than the total amount owing, a FINANCE CHARGE may be included on your next monthly statement. A FINANCE CHARGE is applied to ALL accounts beginning 90 days after charges are made to the account.

Insurance:
Insurance is a contract between you and your insurance company. We will complete and submit your insurance claim for you based on the information you provide. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of charges not covered by your insurance within one (1) month of notice from insurance company. You also agree that if your insurance company takes more than 60 days to respond, we shall consider the charges your financial responsibility and it will then be your responsibility to seek reimbursement from your insurance company.

Co-Payments:
You are responsible for any co-payments , deductibles, co-insurance and/or non-covered services, materials or items considered "not medically necessary" by your insurance company and must be paid for at the time of service. If payment cannot be made at each visit, notify the front desk staff to make other arrangements.

Medicare Patients:
Our office will submit claims for services to Medicare and your secondary insurance. You are responsible for deductibles, co-payments and any non-covered services.

Parent/Guardian/Child:
The adult accompanying the child is responsible for payment at the time of service, including co-payment. The parent/guardian with whom the child resides is the person who will be billed for services rendered. We will not be involved in mediating financial arrangements between parents/guardians and we will bill insurance as stated above.

Self-Pay Accounts:
Self-pay accounts are those patients without insurance coverage or patients who are covered by an insurance that this office does not participate with. For these accounts, payment is required at the time of service for all services.

The staff at Eye Care Group is happy to assist you with questions and concerns regarding your specific insurance plan and to help facilitate communication with your insurance company. It is difficult, however, for health care providers to become familiar with the details of every insurance plan they encounter. *It is the responsibility of the patient, and in your best interest, to know what is covered and what is excluded from your personal plan.* Thank you.

I have read and understand the above payment policy and payment options:

Signature: _____ Date: _____
(Patient/Parent/Legal Guardian/Representative)

Scott M. Walters, OD
Daniel J. Vidlak, OD
Jeffrey S. Pelson, OD 1022 NW 6th Street Grants Pass, OR 97526 (541) 476-4545
James F. Adamek, OD 335 Caves Hwy Cave Junction, OR 97523 (541) 592-3921