IMPORTANT FINANCIAL & INSURANCE FILING POLICY

- **All charges are your responsibility, whether or not your insurance company pays.**
  - ✓ *I understand that I am ultimately responsible for any bill incurred in this office. Should my account become delinquent, I will be responsible for any & all legal fees, court costs, & collection charges. There will be a service charge for each returned check.*
  - ✓ *Not all services are covered in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We cannot become involved in disputes between you and your insurer regarding covered charges, deductible, or copay.*
  - ✓ ***Contact lens prescription requires doctor's fitting and evaluation, and the fee is always separate from comprehensive eye exam and refraction. Contact lens fee can vary depending on types of contact lenses and the level of difficulty. In most cases, Contact Lenses can be shipped within the United States at no charge. In the event there is a fee, I understand I am responsible for all necessary charges.***

- If TRINITY VISION CENTER is **out-of-network** for your medical insurance:
  - ✓ *It is your responsibility to pay the full usual and customary fee at the time services are rendered, in order to file the claim to your insurance.*
  - ✓ *Under your approval, TRINITY VISION CENTER will submit the claim for you and reimburse you the amount paid back by your insurance company, which may be different from our usual and customary fees.*
  - ✓ *If you haven't met your deductible, your payment will be applied toward your deductible.*
  - ✓ *In case where you accept discount on services offered by TRINITY VISION CENTER, neither you nor TRINITY VISION CENTER will be allowed to file the insurance claim for the services rendered*.

- If TRINITY VISION CENTER is **in- network** with your medical insurance:
  - ✓ *If your insurance company does not pay your claim within 30 days, it is your responsibility to contact them to expedite payment. If your insurance company refuses to pay, you are responsible for payment.*
  - ✓ *Payment for copay and/or deductible is due at the time services are rendered.*
  - ✓ *In the event that refraction is not covered by your insurance you will be charged a fee in addition to your copay and/or deductible.*

- Vision Plans:
  - ✓ *I understand that vision plans (VSP, Eyemed, etc.) cover only for routine annual/biannual vision exams and **DO NOT** cover for medical eye problems. I also understand that in case where medical eye problem is detected during a routine examination, TRINITY VISION CENTER is allowed to bill my medical insurance or myself directly for the services rendered.*

- **AUTHORIZATION TO RELEASE HEALTH INFORMATION & ASSIGN BENEFITS**
  - ✓ *I authorize the release of all necessary Protected Health Information & assign all medical & vision benefits to **TRINITY VISION CENTER.** I also request that payment of authorized Medicare (if applicable) benefits be made on my behalf to **TRINITY VISION CENTER** for any services furnished to me by **TRINITY VISION CENTER.***
  - ✓ *I authorize any holder of medical information related to me to release to the Centers for Medicare & Medicaid Services (CMS) & its agents, any information needed to determine these benefits or the benefits payable to related services. I understand that my signature requests that payment be made & authorizes release of medical information necessary to pay the claim.*

- This authorization & assignment will remain in effect until revoked by me in writing. A photocopy/scanned image of this authorization & assignment is to be considered as valid as the original. I request that you file my insurance & I have agreed to, and completed, all of the conditions listed above. I have read & understood this information & I am signing voluntarily.

Name: (please print):_____

X_____

Patient or Legal Guardian's Signature Date