CHESTER COUNTY EYE CARE

LAST NAME	FIRST NAME	M.I.	SSN	DATE OF BIRTH	SEX	MRN

STREET ADDRESS	STREET ADDRESS CONTD.

CITY	STATE	ZIP CODE	HOME PHONE	CELL PHONE

Financial Agreement

UNIFORM OF ASSIGNMENT, RELEASE OF INFORMATION, AND FINANCIAL DISCLOSURE:

PATIENT FINANCIAL RESPONSIBILITY POLICY FORM

Thank you for choosing Chester County Eye Care Associates as your eye care provider. We are honored by your choice and are committed to providing you and your family with the highest quality eye care. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

ASSIGNMENT OF BENEFITS:

I hereby assign or transfer payment benefits made to me and by behalf to Chester County Eye Care Associates, P.C. for any services furnished to me by this physician/supplier. I further agree that I am responsible for payment or charges incurred by me that are not covered by my insurance or for which my insurance has paid me.

RELEASE OF INFORMATION:

I hereby authorize Chester County Eye Care Associates, P.C. to release information acquired during the course of my examination or treatment to my referring physician, my primary care doctor, or to an appropriate insurance carrier. If Medicare patient, I further authorize release to the Center of Medicare Services and its agents any information needed to determine benefits payable for related charges.

INSURANCE COVERAGE

It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations as well as authorization requirements. This information is furnished by your insurance company. If your insurance requires a referral, it is your responsibility to obtain one prior to your visit. If you do not have one, you may sign a waiver stating that you will be responsible for payment in full if the referral is not received within one day. Alternatively, you may reschedule your appointment.

Just as we make every effort to accommodate you when you are in need of eye care, we expect payment in full on receipt of your billing statement. The statement will reflect the amount you owe after your insurance has processed your claim. If no resolution can be made within 30 days, the account will be sent to the collection agency, you will be unable to schedule future appointments and dismissal from the practice may be initiated.

INSURANCE PAYMENTS SENT TO YOU

If insurance payments are sent to you, you are responsible for forwarding these payments to our office with a copy of the Explanation of Benefits received from your insurance company.

INSURANCE CHANGES

If you have had any changes in your coverage, please notify us. Even a small discrepancy can lead to a denial of payment.

CO-PAYMENTS, DEDUCTIBLES, CO-INSURANCE AND PAST DUE BALANCES

All co-payments are collected at the date of service.

Past due balances are due at the date of service unless previous arrangements have been made with an insurance counselor. Insurance deductibles and fees for service not covered by your insurance policy are due at the time of service.

An example of a non-covered service is REFRACTION (unless you have a vision plan). REFRACTION is a procedure necessary for eye doctors to evaluate your vision and/or write glasses prescriptions. Unfortunately, many insurance companies, including Medicare, do not cover this procedure. Our fee for this service is $45, and is expected at the time of check-out. This fee is subject to change.

If, for any reason, you are unable to pay for services at the date of service, we will reschedule your appointment.

Our office accepts VISA, MasterCard, American Express, Discover, cash, money orders and checks. No post-dated checks will be accepted. Any bounced check will incur a $35 charge.

SELF PAY PATIENTS

You are responsible for your payment in full at the time of service. NO SURPRISES ACT

In accordance with the No Surprises Act, you are entitled to receive a Good Faith Estimate for services not covered by insurance or if you are a self-pay patient.

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STORED CARED ON FILE

Chester County Eye Care Associates will not store your credit card credentials unless you authorized us to do so. Credit card information is stored in a secure encrypted and tokenized format as per the regulations of the credit card brand requirements - Only the last 4 digits of the card on file are visible. You have the ability to manage any credit cards you have stored by logging into your Patient Portal.

AUTOPAY

If you enrolled in AutoPay, you authorize Chester County Eye Care to charge the full balance due after your insurance company adjudicates your claim. You can set the maximum amount to be processed. You will receive notification within 10 days of the charges. The notification will include a link providing you the option to opt out of the next payment.

FAILURE TO PAY

Patients who ignore collection notices or fail to pay their balances risk negative credit ratings and possible dismissal

from the practice. Patients with past due balances who have not signed a formal payment arrangement, are past due on a formal payment arrangement or are currently in collections will no longer be able to schedule an appointment.

MISSED APPOINTMENTS

If you need to cancel an appointment, we ask for at least 24 hours' notice. This allows us to offer the appointment to another patient. If multiple appointments are missed without notice to us, you may be discharged from the practice. We hope this clarifies any issues you may have about our office financial policies.

Signing below verifies that you have read and understand this form and that you will abide by the policies stated. Please feel free to ask our insurance staff any questions about our policies.

Patient / Agent/ Guardian Signature