Davis Eye Clinic

AGREEMENT TO PAYMENT POLICY AND INSURANCE PROCEDURES

As your physician, I try to provide the best care possible. Sometimes certain services or diagnostic tests may be required to take care of you, which are not covered by your insurance. Most insurance companies require a medical diagnosis in order to cover eye care, and when applicable, I will provide this. Often, such services as routine exams and refractions are not covered by insurance unless you have a vision plan. If you have a vision plan, as well as medical insurance, please present all of those insurance cards to the receptionist. You will be expected to pay for non-covered services at the time of the visit.

I have been informed and understand that my medical insurance may not cover routine eye exams, for example; myopia, hyperopia, and presbyopia. For my medical insurance to pay, I must have an injury or disease of the eye, for example; glaucoma, cataract, diabetic retinopathy, chalazion, blepharitis or conjunctivitis. These are only a few examples of the many diseases or injuries to the eye.

Patient records are accessible through our web portal at www.MyEyeCareRecords.com. To register, you will need to enter the exact first and last name as it is saved in our database, social security number, date of birth and insurance policy number, along with a valid email address, and the initial default password (1234). You will then change your password to access your personal eye records.

I HAVE READ YOUR POLICY AND AGREE TO PAY FOR SERVICES NOT COVERED BY MY INSURANCE, AS INDICATED BY MY SIGNATURE. I AGREE TO PAY ALL COSTS, PRESENT AND FUTURE, RELATING TO MY TREATMENT. I AGREE TO PAY THE CHARGES WHEN DUE. I ALSO AGREE TO PAY REASONABLE COLLECTION COSTS, INCLUDING ATTORNEY FEES, COURT COSTS AND INTEREST AT THE RATE ALLOWED BY LAW, SHOULD COLLECTION BECOME NECESSARY.

I authorize the release of medical information and records concerning my treatment to Medicare, Medigap, and/or other insurance companies and assign my claim for benefits to Davis Eye Clinic, to the extent permitted under applicable law or insurance agreements. I agree to allow Davis Eye Clinic to request and release my medical records from other physicians or medical institutions as it deems necessary for my medical care, and I further authorize the release of my medical records by such parties for such purpose. I release the Davis Eye Clinic from all legal responsibility or liability that may arise from the above authorizations and agreements.

SIGNATURE **DATE**

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******PLEASE BRING ALL INSURANCE CARDS TO THE WINDOW******