ELITE VISION, P.C.

INSURANCE AUTHORIZATION AND BINDING FINANCIAL AGREEMENT/HIPAA

Providing the best possible eye care involves a mutual understanding between patient and provider. Should you have any questions regarding the following policies, please ask for clarification. Our professional services are rendered to you, not your insurance company. Ultimately, payment for our services is your responsibility.

- I authorize ELITE VISION to release any information regarding my care to expedite claims or for records transfer should such events be required.
- I hereby authorize ELITE VISION to bill my insurance company for services provided to me and with payment made directly to the providing doctor's office and that such authorization is valid until written notice is provided to cancel that authorization.
- **While ELITE VISION makes considerable effort to verify my insurance coverage, benefits, and cost shares, I understand that such information is NOT an official or legally binding estimation of my out-of-pocket expenses. Ultimately, my final cost share is dependent on the decision of my insurance carrier. I UNDERSTAND THAT ANY COPAY ESTIMATES GIVEN TO ME PRIOR TO MY EXAMINATION MAY TURN OUT TO BE DIFFERENT FROM THE FINAL DECISION OF MY INSURANCE CARRIER AND I AGREE THAT I AM DIRECTLY AND FULLY RESPONSIBLE TO ELITE VISION FOR PAYMENT OF ALL CHARGES, INCLUDING ANY AMOUNT IN EXCESS OF PREVIOUS COPAY ESTIMATES. I realize that if my insurance company fails to pay its anticipated balance in full or payment is not made within 45 days it is my responsibility to pay the doctor's bill and that I will pay collection fees, attorney's fees, court costs, etc. for the purpose of collection on delinquent accounts.**
- In the event that I receive payment from my insurance company for services provided in this office, I agree to endorse any received payment to the doctor's office.
- I understand that all optical products including contact lenses and prescription glasses are custom made and not eligible to be returned for a refund. In the event that you have difficulty adapting to progressive addition lenses, we can change the lenses to lined bifocals or single vision lenses within 30 days at no additional cost to you.
- **I understand there may be medical findings during the course of my exam. I understand it is a VIOLATION of ELITE VISION's provider agreement with my insurance to bill such medically related services to my vision wellness plan. In this event, my medical insurance will be billed and I understand I will be responsible for any applicable copays, cost-shares, and/or deductibles. I also understand that ELITE VISION will not neglect medical findings in order to bill my vision wellness plan, as that would put ELITE VISION in direct conflict with its ethical obligations to the Colorado Board of Optometry.**
- I understand there is a $35 fee for all returned checks.
- The Colorado Board of Optometry requires patients to be notified of the following: ELITE VISION maintains patient records for a period of 5 years and it does so in a manner that is confidential. After 5 years records may be destroyed in a manner which also protects your confidentiality.

I understand and agree to all statements made herein and understand this is a legally binding agreement.

Printed Name: ______________________________

Signature: ______________________________ Date ____________

Witness ______________________________ Date: ____________

NOTICE OF PRIVACY PRACTICES

By signing below you attest that you have received, reviewed, and understood this practice's privacy policy and the rights to privacy that you are afforded by federal legislation (HIPAA Privacy Act). The privacy policy outlines how your information is shared only for the purpose of performing service or collecting payment. These policies are subject to change or modification without notice.

Signature ______________________________ Date ____________