Wyoming Vision Center
Financial Policy
HIPAA Acknowledgment

We are committed to providing you with the best possible care, and we are available to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions regarding our fees, financial policy, or your responsibility. We accept cash, check, Visa, MasterCard, Discover, and American Express for your convenience and expect payment when services are rendered.

As a courtesy we will file your insurance claim for you as long as you provide all the required information. For example: copy of all insurance cards, insured's social security number, insured's date of birth, and the insured's employment information are all required.

I understand and agree that, I am ultimately responsible for the balance of my account for any professional services rendered including but not limited to charges incurred from any and all exams, office visits, additional testing, contact lens fits, contact lens boxes, or glasses and glasses repairs of any kind regardless of having insurance or not. If I choose to not pay any outstanding balance, I could be responsible for court costs and attorney's fees, and interest charges of 1.75% monthly on any outstanding balance not paid that is sent to small claims court. In the event of collection procedures, attorney fees and court costs are my responsibility. I also understand that the delinquency fee with regards to collections will be equal to 50% of the principal amount owed.

I authorize the release of medical information or any other information as needed to submit an insurance claim for myself or any other dependent child with whom I have financial responsibility for. I authorize the use of the signature below on all insurance submissions. I authorize the payment of insurance benefits to Wyoming Vision Center.

Patients under the age of 18 should be accompanied by a parent or legal guardian. The parent who signs the financial policy form is responsible for payment of services. In the event the minor comes unaccompanied to our office, we MUST have a signed authorization for treatment form as well as payment for services rendered.

I hereby acknowledge that I have received and/or read a copy of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Policy.

I certify that I have read and understand the financial and HIPAA Privacy Policy of Wyoming Vision Center

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Patient Printed Name

_____ _____

Patient/Parent/Guardian Signature Date

5/11