Coastal Family Eye Care, LLC
Financial Policy and Acknowledgment of Receipt of NPP

Thank you for choosing us as your eye care provider! We are committed to providing you with quality and affordable vision care. Please understand that the payment of your bill is considered a part of your treatment. We are committed to providing the best treatment for our patients and we charge what we believe to be reasonable and customary fees for our region and specialty. The following statement explains our *Financial Policy*, which we ask you to read, sign and return to us prior to your treatment.

- All patients should provide complete personal and insurance information prior to being seen by the doctor.
- All applicable co-pays, personal balances, both current and prior, are due at time of service.
- We accept cash, check, Visa, MasterCard, or Care Credit

Insurance & Claims Submission

We participate in most medical insurance plans. For a complete list, please speak with our front desk staff. If you are not insured by a plan we are in-network with, payment in full is expected at each visit. If you are insured by a plan we are in-network with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. We will do our best to obtain accurate information regarding your eye care benefits. Please contact your insurance company with any questions you may have regarding your coverage. If we are not able to collect payment from your insurance company within 60 days, you may be asked to pay the remaining balance within 30 days. Please remember that your insurance benefit is a contract between you, your employer, and your insurance company. You are personally responsible for any bill, or portion thereof, not paid by your insurance company.

Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of your visit and we will do our best to make you aware of non-covered services before you see the doctor. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

Payment is required in full for all optical orders including eyeglasses, lenses, and contact lenses prior to the order being placed. Additionally, we do not offer refunds on eyeglasses or opened contact lenses.

Past Due Accounts

Overdue accounts will be referred to a collection agency. Legal fees that we pay to secure past due balances will be added to your account. Checks returned for non-sufficient funds must be paid in full within 10 days or are turned over to The Thomas Agency and subject to applicable fees. For checks returned to us as unpaid by your bank, we will charge a $15.00 fee. These payments must be made in the form of cash, Visa, or MasterCard.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have a certain right to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan and direct treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly, obtain payment from third-party payers and conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

_____ _____

Patient Name **Verbal Consent Signature**

_____

Date

Appointment Reminders

Text ☐ **Email** ☐ **Phone** ☐