ACKNOWLEDGMENT AND CONSENT

I understand that Wilsonville Vision Center

(referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I <u>have received</u> a copy of the Notice of Privacy Practices.

By:_____ Date:_____
(Patient)

-OR-

By:_____ Date:_____
(Patient representative)

Description of Representative's Authority:_____

Wilsonville Vision Center
Dr. J Richard Christiansen O.D
29890 Town Center Loop W. Ste E
Wilsonville, OR, 97070
(503) 682-3234

FINANCIAL POLICY

As a service to our patients we would like to outline our office and credit policy to avoid any misunderstandings.

- As a courtesy to you, Wilsonville Vision Center will gladly bill your PRIMARY INSURANCE when you provide us with the correct and current information. Payment from your insurance company is to be paid to Wilsonville Vision Center. All benefits quoted are not a guarantee of payment by your insurance company and final determination can only be made when the claim is processed.

- Wilsonville Vision Center cannot accept responsibility for collecting or resubmitting insurance claim after 60 days or for negotiating a disputed claim. Insurance reimbursement is a contract between you, your employer, and the insurance company. Ultimately YOU are responsible for the timely payment of your account.

- All copays are due at time of service.

- Wilsonville Vision Center requires ½ down on any eyewear purchased before we place an order. Full payment is required before taking your eyewear home.

- Visa, MasterCard, Discover, debit cards, checks and cash are all accepted forms of payment.

- There is a $35.00 charge on all returned or NSF Checks

- Bad checks will be turned over to the District Attorney for prosecution.

- After 90 days, delinquent accounts may be assigned to a credit reporting collection service and a $50 fee will be added to your account. If it becomes necessary to effect collections you will be responsible for all costs and expenses, including reasonable attorney fees.

I have read this office and financial policy and understand that regardless of any insurance coverage I may have, I am responsible for payment on my account. I hereby authorize the doctor to release information necessary to secure payment. This will ensure that our responsible patients will not be penalized to cover costs incurred by those who do not pay on time.

_____

Signature of patient or parent/legal guardian **Date**