

Heights Eyecare Financial Policy

Dr. Linde and Dr. Kimball, along with the staff, are pleased that you have chosen us for your eye care needs. We would like to make you aware of our financial policy and appreciate your cooperation. Please review and sign.

EXAMINATION/TREATMENT - Payment in full is due at the time of service.

PRODUCTS (contacts, glasses, etc.) - Payment for products requires 50% down upon ordering and the remaining balance is due upon receipt of the product.

BILLING INSURANCE - We will gladly bill your **primary** insurance but you are ultimately responsible for all charges not paid for by your insurance company. The billing of any secondary insurance company is your responsibility.

CO-PAYMENT - The patient share of the bill is due at the time of service.

FLEX / CAFETERIA PLANS - Payment **in full** is due at the time of service. We will provide a "paid" receipt for direct reimbursement **to you**.

We accept cash, checks, debit cards, MasterCard, Visa, and Discover.

I acknowledge that I am responsible to pay for all charges for treatment/services administered by Heights Eyecare. I understand and agree to the above terms of payment. I understand that if I fail to make my payments my account may be turned over to a collection agency. I understand and agree to pay reasonable attorney and/or collection fees accrued due to my delinquent account.

Signature

Date

Acknowledgement of Privacy Practices

I acknowledge that I have been informed of Heights Eyecare Inc.'s Notice of Privacy Practices, and a copy of such has been made available to me.

Patient name _____

Signature _____ Date _____

Optomap Consent

(Circle One)

I, (elect / decline) the Optomap _____ (initial/date)

I, (elect / decline) the Optomap _____ (initial/date)

I, (elect / decline) the Optomap _____ (initial/date)

I, (elect / decline) the Optomap _____ (initial/date)