Linda R. Price, O.D.

Required Signatures:

Financial Policies and Patient Responsibility:

In order for us to file your insurance, we must be notified and have prior authorization from the insurance company before your exam, otherwise you will be considered non-covered and will be responsible for all charges incurred.

Our office will attempt to accurately obtain your coverage and charge you in accordance to your insurance benefits. While we will do everything we can to keep you informed of covered vs. non-covered services (as quoted by your insurance company), final determination of coverage and payment is not made until your insurance claim is reviewed by your insurance company. By signing below, you understand that payment collected today is based on a quote from your insurance company and is not a guarantee of benefits. In cases where professional goods and services are not covered (therefore, denied) by your insurance company, it will be the patient's responsibility to pay for these services in full. Claims not paid due to errant or undisclosed insurance information provided by the patient will be the responsibility of the patient as well. If we are not on your insurance plan, we require full payment for all services and products at the time they are rendered, but will provide you with an itemized receipt that you may submit to your insurance plan for potential reimbursement.

Should you have a problem with the eyeglasses or contact lens prescription you must return within 60 days to be rechecked at no charge.

I have read and understand the financial policy of Linda R. Price, O.D. and I do accept financial responsibility:

_____ _____

(Signature of Responsible Party) (Date)

HIPAA Privacy Rule Authorization

I authorize Linda R. Price, O.D. to discuss the results of my eye examination as well as any financial details with my parents and/or spouse.

I authorize Linda R. Price, O.D. to contact me by phone or any other media devices for communications needed to monitor my progress and care

I authorize the transmission of my current prescription via fax or encrypted email to my requested dispenser.

_____ _____

(Signature of Responsible Party) (Date)

Vision vs. Medical Insurance and Assignment of Insurance Benefits:

Vision insurance coverage is designed to cover routine eye services and to determine a glasses and/or contact lens prescription. When a medical condition or diagnosis is present, it may be necessary to file your examination to your medical insurance. Many times, we may not be aware of any medical diagnosis beforehand. These rules are often dictated by the insurance carriers themselves. In either case, the patient is responsible for any financial responsibility as dictated by their respective insurance company.

I authorize the payment of my medical/vision benefits to Linda R. Price, O.D. I authorize Linda R. Price, O.D. to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

_____ _____

(Signature of Responsible Party) (Date

Notice of Privacy Practices, Non-Discrimination Policy and Notice of Language Assistance

I acknowledge that I received a copy of the above notices from Linda R. Price, O.D.

_____ _____

(Signature of Responsible Party) (Date)

Contact Lens Policies

I acknowledge receipt of Contact Lens Policies and prescription by Linda R. Price, O.D.

_____ _____

(Signature of Responsible Party) (Date)