

RICHMOND VISION CARE OPTOMETRY

INSURANCE AUTHORIZATION AND BINDING FINANCIAL AGREEMENT

Providing the best possible eye care involves a mutual understanding between patient and provider. Please review the following policies, and let us know if we can answer any questions. Thank you for your trust.

- ❖ I authorize Richmond Vision Care Optometry to release information regarding my care to my insurance company in order to expedite claims or for records transfer should such events be required.
- ❖ I authorize Richmond Vision Care Optometry to bill my insurance company for services provided to me, with payment made directly to the providing doctor's office and that such authorization is valid until written notice is provided to cancel that authorization.
- ❖ I understand that Richmond Vision Care Optometry participates with both **Vision Plans** (ex. VSP, EyeMED, etc.) for routine wellness exams, as well as **Medical Insurances** (ex. Medicare, Anthem, BCBS, PPOs etc.) for eye health issues. The appropriate plan will be billed for any given service. Unfortunately, Richmond Vision Care Optometry is unable to participate with HMOs such as Kaiser. I understand that if RVCO does not participate with my plan, I am free to pay out of pocket at the time of service and seek any out-of-network reimbursement directly from my insurer.
- ❖ While Richmond Vision Care Optometry makes every effort to verify my insurance coverage and benefits before services are provided, I understand that such information is NOT an official or legally binding decision of my out-of-pocket expenses. Verification of coverage is done as a courtesy only, and is not a guarantee of insurance coverage. Ultimately, my final costs are dependent on the final decision of my insurance carrier. I understand that if my insurer does not pay, or only partially pays, I am responsible for payment in full of any remaining balance for services rendered.
- ❖ In the event that I receive payment from my insurance company for services provided in this office, I agree to endorse any received payment to the doctor's office.
- ❖ I understand there is a 25% restocking fee for all returned materials. There are no refunds after 30 days.
- ❖ Contact Lens Service Fees: I understand contact lens services are not an included part of a routine eye examination, and may or may not be covered by vision plan benefits. Additional fees apply according to lens type and services required.
- ❖ Richmond Vision Care Optometry maintains patient records for a period of 7 years or until minors turn 19, and it does so in a manner that is confidential. After 7 years, records will be destroyed in a manner which also protects your confidentiality.

NOTICE OF PRIVACY PRACTICES

By signing below I attest that I have received, reviewed, and understood this practice's privacy policy and the rights to privacy afforded by federal legislation (HIPAA Privacy Act). The privacy policy outlines how my information is shared only for the purpose of performing services or collecting payment. These policies are subject to change or modification as the laws change.

I understand and agree to all statements made herein and understand this is a legally binding agreement.

Signature: _____ Date _____

Print name _____ Guardian _____