Financial Policy and Agreement for Atlantis Vision Center

Release of Information: We ask for sensitive information. We understand people are concerned about the exposure of this information and we have policies and procedures in place to protect all your information. Atlantis Vision Center may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation which is or may be liable or under contract for reimbursement to Atlantis Vision Center for services rendered, and any health care provider for continued patient care.

Payment: I agree that in return for the services provided by Atlantis Vision Center, payment is due at the time the service is rendered. We accept cash, personal checks, MasterCard, Visa, Discover and American Express. Returned checks are subject to the following service charge starting at $25.00 but will not exceed 5% of the face value. In addition, you will lose your privilege to write a check to our office. Past due account will be subject to a service charge of 1.5% per month (18% APR).

Insurance: The doctor's service is provided directly to you and not to an insurance company. We cannot render services on the assumption that charges will be paid for you by the insurance company. As a courtesy to our patients, we submit medical claims to primary, secondary, and tertiary carriers with whom we are contracted. We do not bill carriers that we are not contracted or third-party carriers, this is the responsibility of the patient. You will be expected to pay any copay, deductible, co-insurance and non-covered amounts determined by your policy at the time of service. If your insurance company has failed to pay within a 60-day period, we will expect you to pay the balance of your bill in full. You must then collect from your insurance company. We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company. All charges are your responsibility from the date services are rendered.

Medicare/Managed Care: I request that payment of authorized Medicare benefits be made on my behalf to Atlantis Vision Center for services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare, and its agents, any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

Print Patient Name: _____ DOB: _____

Patient/Guardian Signature: _____ Date: _____