



Patient Name:  
DOB:  
Patient Number:

Understanding and Agreement of:

- I consent to the necessary treatment for the above named patient and acknowledge receipt of the Notice of Privacy Practices.
- I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.
- I request and authorize that payment of my insurance benefits be made on my behalf to the doctor and associates providing my care and/or to the Michigan Eyecare Institute, if the organization participates with my insurance.
- I allow fax/electronic transmittal of my medical records if necessary.
- I understand that payment of charges incurred is due at the time of services unless other financial arrangements have been made prior to my treatment.
- I understand that I am responsible for my copay and/or deductible at the time of service.
- I agree to accept full financial responsibility for my office visit, testing and/or surgery if I did not obtain a referral from my primary care physician.
- I grant express consent for Michigan Eyecare Institute, its subsidiaries, and its third-party service providers to use any information provided by me to contact me, including but not limited to mobile phone numbers to be used for both telephone calls & text messaging (additional cost/rates may apply), email addresses, and mailing addresses for any & all purposes related to the services or care I receive. I also understand and consent to allowing Michigan Eyecare Institute, its subsidiaries, and its third-party service providers to contact me at any phone number I provide using automated telephone dialing equipment (ATDS) and/or an artificial or pre-recorded voice system.

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Signature of patient or Legal Guardian

Date

**With whom may we discuss your medical care:**

\_\_\_\_\_  
Name:

\_\_\_\_\_  
Relationship:

\_\_\_\_\_  
Name:

\_\_\_\_\_  
Relationship:

\_\_\_\_\_  
Name:

\_\_\_\_\_  
Relationship:

**FOR MINORS** - In my absence, I permit Michigan Eyecare Institute to treat my child if accompanied by the following adult:

\_\_\_\_\_  
Name:

\_\_\_\_\_  
Relationship:

\_\_\_\_\_  
Name:

\_\_\_\_\_  
Relationship:



Patient Name:

DOB:

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**MEDICARE ENROLLEES:**

I request that payment of authorized Medicare benefits be made to either me or on my behalf to the doctor and associates of the Michigan Eyecare Institute providing my care for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Michigan Eyecare Institute for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

I request that payment of authorized Medicaid benefits be made either to me or on my behalf to the doctor and associates of the Michigan Eyecare Institute providing my care for any services furnished to me by that physician. I \_\_\_\_\_ will provide all information needed to determine these benefits payable for related services.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date



## **FINANCIAL POLICY**

Thank you for choosing our practice as your healthcare provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

### **Co-Pays and Deductibles**

All copayments, deductibles, and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check, or credit cards. Absolutely no post-dated checks will be accepted.

### **Insurance Claims**

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company does not pay for any of your services performed at our office, you may be responsible for the complete balance of the non-payable services. If we are out of network with your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

### **Workers' Compensation and Automobile Accidents**

In the case of a workers' compensation injury or automobile accident, you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier prior to your visit. If this information is not provided, you will be asked to reschedule your appointment or pay for your visit at the time of service.

### **Missed Appointments**

Appointments missed and are not previously canceled may be charged a fee of \$25.00. Excessive cancellations and no-showed appointments may be subject to discharge from the practice.

### **Refractive Fee**

The determination of the refractive state of your eyes is rarely covered by medical insurance and never covered by Medicare. If your insurance does not provide coverage for this service, you will be asked to pay \$40.00 for this service when it is provided.

### **Returned Checks**

The charge for a returned check is \$25.00 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash or credit card only basis following any returned check.

