NORTH VALLEY Eye Care RIDGE EYE CARE ROYO Eye Care

Financial Policy and Disclosure Statement

Patient Legal Name:_____ **Date of Birth**:_____

PATIENT RESPONSIBILITIES

- The person identified as the guarantor of the account is responsible for payment of charges. This person is identified on the patient information form, and can be updated at any time.
- Minors: The parent or guardian who first brings the minor patient into our office will determine the financially responsible party for the minor's medical expenses. The party identified is required to pay regardless of the provisions of a divorce decree or custody arrangements and regardless of the child's relationship to the insurance subscriber.
- It is the patient's responsibility to inform our office of all insurance plans and provide accurate information. Our office will bill claims to the insurances we are contracted with on behalf of our patients.
- Charges that are not covered by insurance and co-payments are collected at the time of service.
- Please be aware that payment from insurance cannot be guaranteed, and sometimes benefits are not determined until your claim is processed.
- The guarantor will be sent a statement for all balances not covered or adjusted off by insurance.
- It is the responsibility of the patient/guarantor to know what services his/her insurance covers. However, our billing department is available to assist if there are questions. Our billing department can be reached at (530) 433-5050.
- If we do not participate in the patient's plan, then payment in full is required at the time of service. However, the patient/guarantor can file a claim himself/herself. A copy of the procedure and diagnostic codes can be requested at check-out. This can assist in filing insurance claims.
- The patient/guarantor has the option NOT to use insurance and if they do so, they must fill out the "Notice of Exclusion from Health Plan Benefits" form and must pay in full at the time of service.

MEDICAL VS VISION INSURANCE

- Insurance plans differentiate between "medical" and "vision" coverage. Most medical insurance plans, including Medicare, do not pay for routine "vision" services such as refractions and contact lens fittings. Most vision plans do no pay for "medical" services, such as diagnostic tests and procedures.
- While some medical problems are obvious, when you do have an eye problem, it may be almost impossible for you to know if it is a "vision" or "medical" problem. The reason for the visit and the doctor's findings will help us determine which insurance(s) to bill.

OVERDUE BALANCES

- If the patient/guarantor has a balance due, he or she will be expected to make a payment toward that balance before being seen by our providers on subsequent office visits.
- Patients will be sent a statement until all balances are paid.

By signing below, I have read and understood the financial policies of Ridge Eye Care, North Valley Eye Care, and Royo Eye Care and also understand that the practice reserves the right to change any and all fees at any time without notice. I authorize and request that insurance and all other pertinent benefits be made directly to the practice on my behalf for all services furnished to me by any physicians employed by the practice. I authorize the release of any medical information about me necessary to determine benefits for related services.

_____ _____ _____

Signature of Patient/Parent/Guardian/Conservator Date Reason patient is unable to sign

ROYO
Eye Care

Privacy Practices Acknowledgment and Consent Form

☐ I have received your Notice of Privacy Practices and/or I have been provided an opportunity to review it.

☐ I agree that telephone messages regarding my appointments, prescription renewals, lab results, and all other Protected Health Information* ("PHI"), may be left for me on voicemail systems and answering machines at the following telephone numbers, in addition to any other means of contact provided to you by me:

☐ (__ __ __) __ __ __-__ __ __ __ ☐ Home/Office/Cell/Email _____

☐ (__ __ __) __ __ __-__ __ __ __ ☐ Home/Office/Cell/Email _____

[If we need to contact you with Lab results, please place a check mark next to the preferred contact number, if any.]

☐ I agree that my PHI may be shared with my spouse.

☐ I agree that my PHI may be shared with the following other people:

Name	Phone Number	Date of Birth
_____	_____	_____
_____	_____	_____

*as *defined in the Health Insurance Portability and Accountability Act of 1996 and its regulations, ("HIPAA")*

Patient Name (print):_____

Signature: _____ Date:_____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): _____ Relationship to Patient: _____

I understand that I can change any of the foregoing agreements, at any time, by giving written notice to Royo Eye Care. My PHI may be further disclosed by such recipient for the purposes referenced above and that my PHI may no longer be protected by state and federal laws because I have authorized the release of such information. I also understand that if any harm results after the authorized release to such person(s), Royo Eye Care will not be held liable for damages.

Patient Portal

Our highly secured, online Patient Portal has arrived and you are automatically enrolled! You now have 24/7 access to your medical information online as well as several other great benefits. To find out more, please refer to the materials posted in the office or ask anyone of our staff members for more information. If you would like to opt out of the patient portal, then please check the following box. ☐