Pediatric & Adult Vision Care
Financial Agreement and Consent to Treatment

We would like to take a moment to welcome you to our office and assure you that you will receive the very best care available. In order to familiarize you with the financial policy of this office we would like to explain how your fees will be handled.

The following contains important information concerning your financial responsibilities and your treatment at PAVC. Please read it carefully.

_____ _____

Patient Name (print) *Date*

1. **FINANCIAL AGREEMENT**: I understand payment for services is due in full at the time services are rendered. Eyeglasses and contact lenses must be paid in full at time of order. Services are based on medical necessity therefore, it is impossible for PAVC to provide a total cost prior to evaluation. I understand PAVC will bill my insurance as a courtesy, but this is not a guarantee that my insurance will pay for services rendered or materials provided. I understand that if my insurance is out of network that I will hold the responsibility for submitting the claim. It is my responsibility to know my insurance benefits and coverage. I am responsible for all co-pays, co-insurances, deductibles, and services or materials not covered by my insurance. In the event it becomes necessary for PAVC to enlist the services of a collection agency and/or legal assistance, I will be responsible for any collection expenses and reasonable fees.

2. **NON-COVERED SERVICES**: I understand that PAVCôs agreements with health insurance plans (i.e. HMOs, PPOs) relates only to items and services which are ñcoveredò by the insurance plan. I accept full financial responsibility for all items or services, which are determined by my insurance not to be covered, including the refraction fee.

3. **MEDICARE**: I request that payment of authorized Medicare benefits be made on my behalf to Pediatric & Adult Vision Care (PAVC) and its clinics for services furnished me by PAVC. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services 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. If other health insurance is indicated in Item 9 of the CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. PAVC accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare Carrier.

4. **AUTO INSURANCE and LIABILITY:** We expect that Auto Insurance will not pay for the items or services that are described below. The fact that this insurance does not pay for a particular item or service does not mean that you should not receive it. There are good reasons why your doctor has recommended it.
The following items and services below are to be paid by you on the day of service. *These items and services are not limited to the following:*

Items: Materials such as contacts or glasses
Services: Contact lens evaluation, refraction, optomap, and perceptual testing

In the event that the claim goes into litigation the person being treated is responsible for payment of services. We expect you to pay your bill promptly on the day the services are rendered. Once this is done we will fulfill our responsibilities in providing your attorney with necessary medical information.

Proof of financial responsibility is requested prior to services being rendered. Please request proper documentation from the responsible party to be faxed to the office at 724-935-9974. It should include the name of the responsible party, claim number, address, contact personôs name along with their phone number.

5**. VOLUNTARY TERMINATION OF CARE:**
If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered
by this office are charged directly to you, and you, ultimately will be personally responsible for payment regardless of your insurance coverage.

6**. AUTHORIZATION TO BILL:** I have read and understood the above information and agree to comply with these terms. I authorize my insurance company to make payment directly to Pediatric & Adult Vision Care (PAVC) for services and/or materials rendered. I authorize PAVC to release information about me or my dependents necessary to process any and all claims for reimbursement on my behalf.

7**. AUTHORIZATION TO TREAT**: I also authorize Pediatric & Adult Vision Care(PAVC), its agents, and employees, and their agents and employees (collectively referred to as "Healthcare Providers") to furnish optometric care and services, including but not limited to, diagnostic tests, examinations, dilation and other medical procedures, which are deemed necessary in the course of my care. I understand that PAVC may invite student interns (in training to be Optometry Doctors and Optical Technicians) to assist in providing my care.

Please sign after you have read and reviewed our Financial Agreement and Consent to Treatment.

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Patient or Parent/Guardian Signature *Date*