VISION SOURCE®
ROSEMOUNT EYE CLINIC

Patient Name (Printed): _____

## SECTION 1 ASSIGNMENT OF BENEFITS AND FINANCIAL POLICY

The patient/guarantor assigns all the insurance and/or Medicare benefits directly to the Rosemount Eye Clinic and authorizes the release of all necessary information to file and complete the insurance claim(s).

- *I understand that* I am financially responsible for payment of all charges, whether or not paid by insurance, including any charges for services rendered which are denied, not prior authorized, or for any reason not covered by the applicable insurance company. This may include co-payments and deductibles not covered by my insurance.
- *Payment Terms and Conditions:* All balances are due in full within 60 days, regardless of pending insurance claims. If you believe you need more than 60 days to pay your charges, please make arrangements with our billing office.
- *Other Charges:* Unpaid balances older than 30 days may be subject to a monthly finance charge of 2.5% per month. Monthly charges may include a $3 statement fee. Returned checks may be electronically presented to your bank with a $30 returned check fee.
- *Referrals/Disputes:* If for any reason I dispute the payments made by my insurance company, it is my responsibility to contact my insurance company for explanation. If a referral from my primary care clinic is required, and I choose to be seen without it, I agree to be responsible for the charges incurred if my insurance company refuses to pay.
- *Return/Refund Policy:* I understand that every pair of eyewear produced by Rosemount Eye Clinic is custom made to each patient's needs. For this reason, Rosemount Eye Clinic cannot accept returns except in very rare circumstances. In the event that I may receive a refund, I may be charged a restocking fee of 30%. In the event that I choose to restyle to a different frame or lens design (including progressive lenses, multifocals or single vision lenses), I will need to pay for any extra cost. In the event that I choose a less expensive frame or lens design, fees may be retained by Rosemount Eye Clinic.

Patient's signature: _____ Date: ___/___/_____
OR legally authorized representative's signature _____ Date: ___/___/_____
Printed Name: _____ Relationship to patient: _____

## SECTION 2 ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that Rosemount Eye Clinic make every effort to inform you of your rights related to your personal health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

Patient's signature: _____ Date: ___/___/_____
OR legally authorized representative's signature _____ Date: ___/___/_____
Printed Name: _____ Relationship to patient: _____

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**FOR OFFICE USE ONLY**

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement. ***Form sent home (initials):*** _____
- ☐ We weren't able to communicate with the patient.
- ☐ The patient did not have a parent/guardian/legal representative present. ***Form sent home w/child (initials):*** _____
- ☐ Other (Please provide specific details): _____



**Employee Signature:** _____