SUMNER
PRIMARY EYECARE

FINANCIAL RESPONSIBILITY & PRIVACY PRACTICES

FINANCIAL RESPONSIBILITY

I authorize the release of medical and financial information for the purpose of collection of my account.

If Dr. Sumner is a participating provider with my insurance plan, I authorize my insurance benefits to be paid directly to the doctor and **acknowledge that I am financially responsible for any unpaid balance. I agree to pay this balance in full.** I am aware that my insurance carrier may require me to use participating providers and to follow plan requirements, including primary care referral and/or precertification, and that failure to comply could result in my sole responsibility to pay any charges for services rendered.

If Dr. Sumner is not a participating provider with my insurance plan, **I understand that I bear sole financial responsibility for the payment of my account.**

If I do not have any insurance coverage, I agree to be responsible for the full balance.

Payment is expected in full at the time services are rendered. Payment of one half is expected before eyeglasses or contacts will be ordered. Eyeglasses and contact lenses must be paid in full at the time of dispensing.

Signature of patient or guardian _____ **Date signed** _____

Patient Name _____ Insured Name _____

Medical Insurance: Primary Coverage _____ Secondary Coverage _____

Vision Insurance/Plan: Primary Coverage _____ Secondary Coverage _____

Medical Insurance: *If your visit is for a medical eye problem, such as pink eye, cataracts, diabetic testing, or other non-vision issues, or if during your routine vision exam, a medical eye issue is found, depending on your plan, you may be covered by your medical insurance. Be aware that we may need a referral or you may have to return to our office for a follow-up visit.*

Vision Plan: *Covers routine eye exam, refraction, eye health screening -- including diabetic screening -- and prescription for glasses/contacts; some include materials such as glasses and contacts.*

MEDICARE PAYMENT & MEDICAL RECORDS RELEASE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to the office of Dr. Sumner for any services furnished to me by this provider. I authorize the release of medical and financial information to the Health Care Financing Administration and its agents to determine benefits payable for services from this provider. I request payment of authorized secondary insurance benefits to be made to this provider and also authorize the release of medical information to the secondary insurer to determine benefits payable for services from the provider.

Patient signature _____ **Date signed** _____

Patient Name _____ Medicare # _____

Name of secondary insurance _____ Policy # _____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Sumner Primary Eyecare Notice of Privacy Practices (HIPAA).

Date _____

Patient Name _____ **Signature** _____