Thank you for choosing Jaffrey Eye Care as your eye care provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

1. The patient (or patient's parent/guardian, if the patient is a minor) is ultimately responsible for payment of their exam, treatment, and care.
2. We are happy to assist in billing our contracted insurers:
    1. Patients are required to provide us with correct and current information about their insurance at least 1 business day prior to their scheduled appointment, unless appointment is made same day.
    2. Patients are responsible for all charges incurred, in the event that insurance is not provided in a timely manner or information provided is out of date or incorrect.
3. Patients are responsible for payment of copays, deductibles, coinsurance, and all other treatments or services not covered by their insurance.
4. We make every effort to accommodate our patients in a timely manner when eye care services are needed. In return, we ask that our patients make every effort to pay outstanding bills promptly.
5. If a patient is uninsured or insurance is out of network, all payments are due at time of service. We accept cash, checks, and most major credit cards.
6. Some Commercial insurance plans and Medicare consider some services to be non-covered. For example, Medicare does not cover routine vision exams. Therefore, Medicare beneficiaries are not covered for vision correction such as eyeglasses or contact lenses under Medicare Part B. Medicare Part B also does not cover eye refractions. Medicare patients are responsible for payment of routine vision exam and refraction services.
7. Copays are due at time of service. We accept cash, checks, and most major credit cards.
8. Coinsurance, deductible, or non-covered services are due at time of service, if known. Otherwise, payments will be due upon receipt of statement from billing office.
9. Medicare patient payment of non-covered services is due at time of service.
10. For non-routine services, some insurance companies require a referral from the patient's Primary Care Provider. It is the patient's responsibility to request a referral. Failure to obtain a referral may result in charges for services not covered.
11. Patients may incur and are responsible for additional charges, if applicable. These charges include, but are not limited to:
    1. Returned Check Fee: $25
    2. Missed Appointment Fee: $100 (see Missed Appointment Policy for further details).
    3. Interest will accrue on unpaid amounts due over 30 days at a rate of 1.5% per month. To avoid interest charges, you may opt to keep a credit card on file with our office.
    4. After 120 days of non-payment, all fees accrued will be sent to collections.
12. If the Patient fails to reimburse said fees in a timely manner with the above stated policy and should the need arise, the patient agrees to pay any and all collection fees, court costs and attorney fees.

Patient Authorizations:

1. I authorize Jaffrey Eye Care, and the physicians, and/or staff associated with Jaffrey Eye Care to release medical and other information acquired during my examination or treatment to the necessary insurance companies, third party payers, and/or other physicians or healthcare entities required to participate, coordinate, or pay for my care.
2. I authorize assignment of financial benefits directly to Jaffrey Eye Care and any associated healthcare entities for services rendered as allowable under third party payer contracts. I understand that I am financially responsible for charges not covered under the assignment.

3. I authorize Jaffrey Eye Care to communicate with me regarding my financial responsibility for services by mail, text, voicemail, or email, according to the information I provided during patient registration.

☐ Optional: By checking this box, I authorize Jaffrey Eye Care to securely store my credit card information and only charge it when I have an outstanding balance. I am aware that the storage system is compliant with the highest level of security regulations. Once stored, I am aware that the only the last 4 digits of my card are viewable by Jaffrey Eye Care staff.

My signature below indicates that I have read, understand, and agree to the provisions of Jaffrey Eye Care's Patient Financial Responsibility Policies as described by this form.

Client Signature	Date
Witness Signature	Date