Oskaloosa Vision Center, Inc

303 N 1st St, Oskaloosa, IA 52577

FINANCIAL and COMMUNICATION POLICIES

This agreement is between Oskaloosa Vision Center, Inc and the patient/guarantor named on this form.

Payment/Insurance

We expect all patients to pay at time of service. We will gladly submit your insurance claims and assist you in receiving the maximum benefit from your plan. All plans, however, have limitations and do not cover 100% of all our fees. Your contract with your insurance company requires you pay all applicable co-pays and deductibles. These fees must be paid to Oskaloosa Vision Center at the time of service.

It is your responsibility to know the requirements of your insurance company. This includes but is not limited to: deductibles, co-pays, limitations, maximum benefits, waiting periods, pre-existing conditions, and prior approvals. Insurance contracts vary from company to company, patient to patient; so we may be unable to communicate all the details of your insurance plan with you. You may speak directly with your insurance company or your employer for this information.

Your insurance plan is based on a contract between your employer or a benefit group. It is not based on your individual optometric needs. You are responsible for all charges your insurance does not cover.

Divorce

In the case of divorce or separation, the parent authorizing treatment for a minor will be the person responsible for the subsequent charges. If the divorce decree requires the other parent to pay all or part of treatment costs, it is the authorizing parent's responsibility to collect from the other parent. WE WILL NOT collect from them.

Past Due Accounts

We will take necessary steps to collect any debt by means of a collection agency or attorney.

Communication

We take every effort to ensure the privacy of your conditions and medical records. If you would like us to communicate with any other persons who may be involved in coordinating your care or payment for your care please indicate below.

Name	Relationship	Appointments	Medical Info	Billing	Orders

I understand this authorization will continue in force and effect until I notify the office staff of Oskaloosa Vision Center of any changes.

Patient's Name:______________________________ Date: ______________

Responsible Party
if not the Patient
Signature: ______________________________ Date: ______________