FINANCIAL POLICY

UTAH EYE CENTERS

Thank you for choosing Utah Eye Centers as your health care provider. Please understand that payment for provided services is due at the time services are rendered. We accept Cash, Checks, and all major Credit Cards. Eye exams normally range from $120.00 to $250.00. Any additional testing, including refractions, are an additional charge.

If You Have Insurance

When we are a Participating Provider, all applicable Co-payments, Deductibles, Lens Fitting, and Refraction charges, which are not covered by your Insurance Company, are **due at the time the service is provided**. ***Refraction*** tests are $60.00 and are necessary to determine if your eye prescription has changed, or if glasses will be necessary to correct your vision. **Medicare** and many supplemental insurances do NOT cover this test. All non-covered services, such as refraction testing, will be the responsibility of the patient and are due at the time of service.

When we are NOT a Participating Provider, the patient is fully responsible for all charges. We will bill your insurance company; however, the remaining balance of the bill is your responsibility, whether or not your insurance company pays. Your insurance policy is a contract between the insurance company and yourself. Please note that some, perhaps all, of the services provided may be non-covered under the Medicare program.

Interest and Collection Fees

All returned checks, regardless of reason, will be assessed a $20.00 fee and any additional collection expenses incurred to recover the original amount due for the medical services rendered.

By signing below, I agree to pay all amounts owed within 30 days of when such amounts are incurred. I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein. I agree that interest will accrue on all past-due amounts at the rate of 18% per annum (1.5% per month) until paid in full. In the event any amount(s) is/are referred to a third party debt collection agency, I agree that in addition to any other amount(s) allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee of up to 40% of the principal amount(s) owing as allowed by Utah Code Annotated, sec.12-1-11. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today. I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me.

I hereby consent to being contacted by telephone at any telephone number (including but not limited to wireless/cellular phone numbers) provided by me or anyone associated with me or acting on my behalf to Utah Eye Centers or anyone acting on its behalf. I understand and agree that such calls may be initiated by Utah Eye Centers or any of its affiliates, agents, contractors or assigns, including but not limited to billing companies and/or third-party collection agency(ies), and that the methods of contact may include using pre-recorded/artificial voice messages and/or the use of an automated dialing device and/or the use of text messages—some or all of which may result in data charges. I also consent to receiving e-mails at any e-mail address provided by me or anyone associated with me or acting on my behalf.

Signature _____ Date _____

Signature of Patient or Responsible Party

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HIPAA Disclosure

We are required to notify you of our privacy practices and have you sign that you have reviewed this information. Utah Eye Centers maintain a record of each patient visit, describing your history, symptoms, exam findings, diagnosis, and suggested treatment. Medical records are needed to provide you with proper care, coordinate with other physicians involved with your care, and for communication with your insurance company. We do not share your personal medical information with any unauthorized entity without your permission. More details of our Notice of Privacy Practices may be found in our written publication.

I have been given a copy of the Utah Eye Centers Notice of Privacy Practices, which describes how my health information is used and shared. I understand that Utah Eye Centers has the right to change this notice at any time.

My signature below acknowledges that I have read and understand the Notice of Privacy Practices.

Signature _____ Date _____

Signature of Patient or Responsible Party

I would like to share my medical information with the follow person(s):

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

UTAH EYE CENTERS

WRITTEN EXPLANATION OF ARBITRATION

1. A binding arbitration agreement requires a patient to submit all future medical malpractice claims to arbitration instead of having those claims heard in a court by a judge or jury.

2. An arbitrator is a person chosen to resolve disputes after hearing the information presented by both sides. A panel of three arbitrators will hear the information presented by both sides and then render a final decision. You select an arbitrator, your doctor selects an arbitrator, and you and the doctor agree on a third arbitrator. In the event we cannot agree, the third arbitrator will be selected by the other two arbitrators from a court-issued list of arbitrators. You and your doctor may also agree that the dispute be heard by only one arbitrator.

3. You pay for the fees and expenses of your arbitrator, the doctor pays for his or her arbitrator, and the fees and expenses of the third arbitrator are shared equally. Should the parties agree that only one arbitrator be selected, the parties will equally share the fees and expenses of the arbitrators.

4. You have the right, at your expense, to be represented in arbitration by an attorney.

5. By choosing arbitration, you also have the right to require mediation. Mediation occurs before arbitration. Mediation is a process by which a neutral person tries to help the parties reach a mutually agreeable resolution of their dispute. The cost of mediation is shared equally.

6. Whether you sign the arbitration agreement or not, is up to you. You will not be treated any differently if you choose not to sign the agreement.

7. You have the right to rescind the agreement within ten (10) days of signing the agreement.

8. The arbitration agreement is automatically renewed each year unless it has been cancelled in writing before the renewal date.

9. You have the right to have all of your questions about arbitration answered.

I have read and understand the foregoing Written Explanation of Arbitration and agree to the terms outlined. I have had the opportunity to ask questions and have my questions answered.

_____ I have received a copy of the complete Arbitration Agreement

_____ I have declined a copy of the complete Arbitration Agreement

_____ _____

Name of Patient Date

_____

Signature of Patient or Patient's Representative