WEST VALLEY VISION CENTER, Inc.

FINANCIAL POLICY

Thank you for choosing us for your health care needs. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment in our office.

All patients (parents or guardians) must complete our Patient Registration form prior to seeing the Provider.

Unless specific billing arrangements are made at each visit, payment for services is due at the time of service. We accept cash, check, Visa, MasterCard, American Express and Discover. **Please remember:**

-Your insurance policy is a contract between you, your insurance company and (possibly) your employer. **As a courtesy to you**, we will bill your insurance company for the services and/or products you receive in our office.
-Insurance companies often set reimbursement schedules that are lower than our usual and customary charges. You may still be responsible for the full amount of our charges.
-You may receive services that your insurance company does not pay for. You will be responsible for these charges.
-**Failure to provide complete and accurate billing and/or insurance information prior to every visit may prohibit our Billing Department from billing the insurance company for your services.** You are then immediately responsible for the full amount of your bill.

By signing below, you are authorizing the release of information to your insurance company so they may pay WVVC directly.

If for any reason we have not received payment from your insurance company within 60 days from your date of service, you become responsible for the outstanding balance. At 90 days, any outstanding balance becomes subject to collection. If your account is sent to an outside collection agency, a 35% fee will be assessed.

I have read, understand, and agree to this financial policy.

Signed:_____ _____
Patient or Responsible Party Signature Patient or Responsible Party Printed Name

Relationship to Patient:_____

Patient Name:_____ Date:_____

NOTICE OF PRIVACY POLICY-ACKNOWLEDGEMENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

_____
Please print your name here

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written **acknowledgement** 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.
- We weren't able to communicate with the patient.
- Other *(Please provide specific details)*

_____ _____
Employee Signature Date

570 Riverstone Way, Suite 3, Fairbanks, Alaska 99709 (907) 479-4700 Fax: (907) 457-5596