Patient Financial Responsibility Form

Thank you for choosing Olson Eye Care for your Vision Needs. We are committed to providing you with the highest quality of vision care. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

- The patient (or guardian) is ultimately responsible for the payment of treatment or care.
- We will bill your medical insurance or 3rd party vision insurance for you. The patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of co-pays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Co-pays are due at the time of service.
- Medicare does not consider the refraction as a covered benefit. The refraction charge is $50.00 and must be paid by the patient.
- Coinsurance, deductibles, and non-covered items are due 30 days from receipt of billing.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include: Charge for return checks - $40.00

Acknowledgement of Privacy Practices

The law requires that Olson Eye Care make every effort to inform you of your rights related to your personal health information.

____ I acknowledge that I was given the opportunity to read, have read, or had explained to me, Olson Eye Care's Notice of Privacy Practice prior to any services.

I allow Olson Eye Care to discuss my protected health information with the person(s) listed below as my personal representative(s):

Name: _____ Relationship: _____ DOB/Phone: _____

Please check all that apply:

- ☐ Medical Information
- ☐ Financial Information
- ☐ Pickup of Materials Purchased

Name: _____ Relationship: _____ DOB/Phone: _____

Please check all that apply:

- ☐ Medical Information
- ☐ Financial Information
- ☐ Pickup of Materials Purchased

By my signature below, I hereby authorize that I am financially responsible for charges not covered by insurance. I have read and understood this form and am signing it voluntarily.

_____ _____ _____

Signature Relationship if not patient Date