

## Patient Billing Agreement

1. I verify that I have reviewed the information on the first page of this form, and that it is correct.
2. I understand that if my insurance claim is denied due to incorrect personal information or incorrect insurance information that I have provided, I will be billed and payment in full will be due immediately.
3. If I have insurance that the Mountain Shadows Vision Center **IS** contracted with, I authorize assignment of payment directly to the Mountain Shadows Vision Center for services and materials provided to me. I understand that the Mountain Shadows Vision Center will file a claim with my insurance company, and that I am responsible for following up with my insurance company to insure my claim is paid within 60 days of my visit date.
4. I understand that if I have a PPO insurance plan, and my insurance has not paid my claim within 60 days of my visit date, that the charges for the visit date will become my responsibility to pay.
5. I understand that, under the terms of the contract that I have with my insurance company, I must pay any pre-determined co-payments at every visit.
6. If I have insurance that that Mountain Shadows Vision Center **IS NOT** contracted with, I agree to pay my bill in full at the time services/materials are provided. I understand that the Mountain Shadows Vision Center will file a claim with my primary insurance carrier as a courtesy, but that it is my responsibility to follow up with my insurance company to insure my personal reimbursement. I understand that the Mountain Shadows Vision Center cannot act as an intermediary between my insurance company and me to effect payment.
7. If I am a patient with **NO** insurance coverage, I agree to pay my balance in full at the time services are rendered and/or materials are ordered.
8. I hereby request and authorize the doctors and personnel of the Mountain Shadows Vision Center to deliver medical care to myself of my dependents listed on page 1 of this form.
9. I authorize any holder of medical information about me to release to the above-mentioned insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.
10. I understand that any returned check is subject to a \$30.00 fee.
11. I understand that a \$25.00 fee will be charged for all appointments missed or not cancelled at least 24 hours in advance.
12. I understand that accounts are subject to a late payment fee of \$5.00 or 1.5% per month if not paid within 30 days of date of service.
13. I understand that cancellations made after an order has been called into the lab will result in me being responsible for the cost of the lenses, plus a \$20.00 cancellation fee. Orders that are cancelled before being called into the lab will result in a \$20.00 cancellation fee.
14. I understand that any outstanding accounts over 60 days will be handed over to a collection agency, unless other arrangements have been made, and any discounts previously quoted will be voided. Any fees incurred will be my responsibility.
15. I understand that if I choose to use my existing frame, I will be charged a \$10.00 handling fee; and that the Mountain Shadows Vision Center, their lab, and any employees or agents thereof will be held blameless for any damage or breakage to the frame that occurs, unless said damage is a direct result of their negligence.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Date: _____	Initials: _____	Date: _____	Initials: _____	Date: _____	Initials: _____
Date: _____	Initials: _____	Date: _____	Initials: _____	Date: _____	Initials: _____
Date: _____	Initials: _____	Date: _____	Initials: _____	Date: _____	Initials: _____