Bluegrass Family Eyecare
Financial Agreement & Consent to Treatment

The following contains important information concerning your financial responsibilities and your treatment at Bluegrass Family Eyecare. Please, read carefully.

Patient Name (print) **Date**

1. **FINANCIAL AGREEMENT: I understand payment for services is due in full at the time service is rendered. A 50% down payment must be made for any glasses at the time they are ordered, with the remaining 50% due at the time of pickup. Because services are based on medical necessity, it is impossible for Bluegrass Family Eyecare to provide total cost prior to evaluation and insurance processing. I understand Bluegrass Family Eyecare will bill my insurance as a courtesy, but this is not a guarantee that my insurance will pay for services rendered or materials provided. I am responsible for all copays, deductibles, and services or materials not covered by my insurance.**
2. **COLLECTIONS: If this account is not paid when due, and Bluegrass Family Eyecare should retain an attorney or collection agency for collection, the undersigned agrees to reimburse Bluegrass Family Eyecare the collection fees of any collection agency, which shall be based on a percentage at a maximum rate of 33 1/3% of the amount due at the time your account is placed with a collection agency, and all costs and expenses incurred for any collection effort on your account, including reasonable attorney's fees incurred by the collection agency. This contract shall cover all medical and vision treatment, services, and products until revoked by either party in writing.**
3. **NON-COVERED SERVICES: I understand that Bluegrass Family Eyecare agreements with health insurance plans (i.e. HMOs, PPOs) relate only to items and service, which are "covered" by the insurance plan. I accept full financial responsibility for all items or services, which are determined by my insurance not to be covered, including the REFRACTION FEE.**
4. **MEDICARE: I request that payment pf authorized Medicare benefits be made on my behalf to Bluegrass Family Eyecare. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated, my signature authorizes releasing the information to the insurer or agency shown. Bluegrass Family Eyecare accepts the charge determination of the Medicare Carrier as full charge and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon charge determination of the Medicare Carrier.**

AUTHORIZATION TO BILL: *I have read and understand the above information and agree to comply with these terms. I authorize my insurance company to make payment directly to Bluegrass Family Eyecare for services and/or materials rendered. I authorize Bluegrass Family Eyecare to release information about me or my dependents necessary to process any and all claims for reimbursement on my behalf.*

AUTHORIZATION TO TREAT: *I also authorize Bluegrass Family Eyecare, its agents and employees (collectively referred to as "Healthcare Providers") to furnish optometric care and services, including but not limited to diagnostics tests, examinations, and any other medical and/or surgical procedures, which is deemed necessary in the course of my care.*

Patient or Parent/Guardian Signature **Date**