Dedicated to Your **TOTAL** Vision Wellness
Jason R. Miller OD, MBA, FAAO
San-San Cooley OD, MS, FAAO
Marcia Hoepf OD
Taylor McGann OD
Michelle Miller OD

Privacy Practices Acknowledgement Form

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name ________________________________ Birthdate __________

Signature ______________________________ Date ____________

FINANCIAL POLICY

We are committed to providing you with the best possible medical care. If you have vision/medical insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

Payment is expected at the time of service, unless we participate in your insurance plan. If we are not listed as a provider for your plan, we will provide you with an itemized receipt showing charges and payments that you can submit for reimbursement. We accept cash, check, MasterCard, Visa, and Discover as forms of payment. There is a $20 fee for all returned checks.

For patients who have vision/health insurance please remember it is your responsibility to make sure that you are eligible for an exam at the time of your visit. You will be asked to pay for your visit in full if you are found to be ineligible for an exam. If we participate in your vision/health insurance plan, we will be happy to submit a claim to your insurance carrier. You are responsible for paying any co-payments or deductibles at the time of your visit. You will be asked to pay for your visit if you do not have your health insurance card, physician referral or completed claim form if one is supposed to be provided. We ask that you notify us of any pre-certification or special limitations that may exist with your insurance carrier.

If your insurance company fails to pay for your claim within 45 days of the date of service, the charges thus become your responsibility and you will be issued a statement from us.

If, after receiving a statement from us, your account becomes 60 days past due, you will be responsible for any fees associated with the collection of your past due account.

Your signature below provides for the release of any medical information necessary to process all insurance claims that the medical payments will be made directly to Dr. Kuhlmann, Dr. Miller, or Dr. Cooley. Regardless of your insurance benefits, if any, you are financially responsible for all fees incurred for services rendered.

I have read and understand the above financial policy.

Signature ______________________________ Date ______________

REFERRALS

You are responsible for obtaining any physician referrals prior to your visit. If no referral is obtained, you will be responsible for all charges on the date of service.

PRIMARY CARE PHYSICIAN or PEDIATRICIAN

____

Patient Name

____

Primary Care Physician or Pediatrician and Clinic Name

____

Address of Primary Care Physician / Pediatrician City State Zip

____

Phone of Physician / Pediatrician Fax

____

Pharmacy Phone

____

Pharmacy Address / Location

____

Signature Date

I authorize the disclosure of my health information to the above Physician.