

### Financial Policy

Thank you for selecting Pendleton Eye Center for your eye care needs.

***Effective 1/16/23, Pendleton Eye Center will be billing through the entity Pacific Eye Institute. Statements for balances due will be from Pacific Eye Institute.*** [redacted] Initial

#### Financial Assignment and Agreement / Authorization to Release

I hereby authorize Pendleton Eye Center and its agent, Pacific Eye Institute to:(1) release any information necessary to insurance carriers regarding my illness or treatments; and(2)process insurance claims generated in the course of examination or treatment. This order will remain in effect until revoked by me in writing.

#### Assignment of Insurance Benefits and Responsibility to Pay

I hereby assign all medical and surgical benefits and hereby authorize and direct my insurance carrier(s) to issue payment check(s) directly to Pendleton Eye Center, and its agent, Pacific Eye Institute, for medical services rendered to myself and/or dependents.

Medical and vision insurance plans are very complex. The purpose of this form is to help you understand your financial responsibilities, and to prevent misunderstandings. Please initial each paragraph of our financial policy, and then sign and date the bottom of the form.

If someone assists you in completing this form, please also have them sign and date at the bottom.

[redacted] I acknowledge that I am financially responsible for all charges for services and merchandise that I obtain from Pendleton Eye Center.

[redacted] I understand that as a courtesy, Pendleton Eye Center will make its best effort to verify my insurance eligibility and Pendleton Eye Center, and its agent, Pacific Eye Institute, will bill my insurance on my behalf.

[redacted] I understand that it is my responsibility to determine my insurance (or employer benefits including deductibles, limits and co-payment amounts. (Co-payments are usually indicated on the front of your insurance card)

[redacted] Deductibles and co-payments (or co-pays are payments I agreed to make when I signed up with my insurance plan. I understand Pacific Eye Institute will not waive or discount deductibles or co-pays under any circumstances.)

[redacted] Co-pays and remaining Deductibles are due on the day of service.

[redacted] I understand there is a \$50 charge for appointments cancelled with less than 24 hours' notice.

[redacted] I understand that, if requested, Pendleton Eye Center will assist me in determining my insurance or employer benefits, and will provide me with an estimate of total charges, however, Pendleton Eye Center will not at any time make a guarantee about insurance eligibility, insurance payments, deductible levels, or co-pay levels.

[redacted] Refraction is the test used to determine your corrected vision and glasses prescription. Most medical insurance plans DO NOT cover the cost of a refraction. I understand that if I request a glasses prescription, I may be required to pay the \$50.00 fee. If you are having a routine vision exam utilizing your VSP Vision Plan, we will bill the insurance for the refraction.

I understand the charges determined to be "patient responsibility" will be billed to me, and must be paid within 30 days of the receipt of the statement. Accounts not paid within the 30 day time period will be considered delinquent. Delinquent accounts will be referred to collections after 90 days of delinquency.

All patients are required to bring their accounts current prior to scheduling elective surgery.

[redacted]  
Patient Name

[redacted]  
Patient/Responsible Party Signature

[redacted]  
Date

[redacted]  
Assistant Name

[redacted]  
Assistant Signature

[redacted]  
Date