Office Policy: Professional fees are paid in full. Please note when billing insurances, the refraction (and contact lens fitting, if applicable) the part of the eye examination determining need for vision correction with glasses and/or contact lenses, will be billed separately from the MEDICAL portion of the examination. Typically, insurance plans, including Medicare, will NOT pay for refraction service unless specifically stated in coverage benefits. This is your responsibility. All professional fees are due at the time of service. It is understood, prior to release of any prescriptions or medical records, my financial account shall be paid in full.

Patient Signature/Responsible Party

Date

Acknowledgement and Consent: Notice of Privacy Practices

*I understand that Christopher Leder, O.D., LLC (aka This Practice) will use and disclose health information about me: health information may include both created and received by This Practice, may be in form of written or electronic records, of spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar type of health related information.

*I understand and agree that this practice may use and disclose my health information in order to: 1)make decisions about, and plan for my care and treatment, 2)refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment, 3)determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care: and 4)perform various office, administrative, and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost effective health care.

*I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by employees, staff and other personnel of This Practice, and my rights regarding my health information. I understand that the Notice of Privacy Practices may be revised from time to time, and I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be available in the reception area.

*I understand that I have a right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

*By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By: _____
(Patient/Representative)

Date: _____

Office Policy

As a service to our patients, we would like to outline our policy toward the payment for services rendered.

1. As a courtesy, your PRIMARY insurance will be billed, provided the necessary ID, **Group numbers, and Billing Address** are provided at the time of visit, unless arrangements have been made prior. After 45 days, the balance of bill becomes your responsibility.
2. As noted, some insurance companies will assist with Coordination of Benefits with automatic transfer to a known Secondary Insurance. We are happy to assist you with secondary claim submission information; however, this office does NOT bill Secondary Insurances separately.
3. Any services or materials considered to be a 'non-covered benefit' by your insurance company will be your responsibility.
4. Insurance copays are required at time of service visit; known unmet medical deductibles shall be required at time of medical service visit.
5. We realize that many families are in a state of change. Divorces, separations, single parents, and blended families are common. In many of these families, the question of who is responsible for the children's care is uncertain. **Our policy is that the parent who requests treatment for the child is responsible for all fees incurred**. If there is a court order in place, please present a copy to the front desk for patient responsibility party payor.
6. We encourage you to contact our billing/crediting department if questions about your account arise. We will be happy to set up a payment plan with you if needed; once an arrangement has been made, you will be expected to follow that plan.

I hereby authorize **Christopher Leder, O.D., LLC** to furnish the insured
insurance company all the information which said insurance company may request concerning my claims for service.

I understand that I am financially responsible for charges NOT covered by my insurance company.

_____
Responsible party's signature

_____
Date