Birmingham Vision Care

Financial Policy

Our goal is to provide you and your family with excellent vision care. We also want to establish and maintain a pleasant, professional working relationship with you. Please take a few moments to review the following information.

- **Payment is expected at the time services are rendered.**
- **In a divorce situation, the adult bringing the child is responsible for payment at the time services are rendered.**

Vision Insurance/Medical Insurance

The ultimate financial relationship is between our office and you, not our office and your insurance company. If you have vision insurance, we will bill your company directly as a courtesy to you. To do this correctly and promptly, we need the most current and accurate information of both your medical and vision insurance, including verification of coverage and proper identification. Prior to your first visit, our staff will attempt to contact your insurance company to determine: effective date, benefits, deductibles, yearly maximums, co-pay %'s, and any other important information which will allow you to receive maximum allowable benefit. We then estimate any costs not covered by your insurance and expect these costs to be paid at the time of service. We cannot guarantee payment of benefits by your insurance company, as initially reported to us. Therefore, we will bill you for any additional costs after the processing of insurance claims. It is ultimately your responsibility to know any special terms, deductibles and/or co-pays for your insurance.

It has become necessary to implement an office policy concerning appointments that are cancelled less than 24 hours prior to be scheduled. Our office will charge $50.00 if not given 24 notice. The unused time prevents other patients the opportunity to be seen.

Privacy Policy

I ___do ____ do not Authorize Birmingham Vision Care to release private health information and or financial to the following person (s). If you are 18 years of age or older and your parents provide your medical coverage, or are responsible for your charges, you must authorize us to release medical and financial information to the responsible party. I understand the named person(s) provide my health benefits and may be contacted concerning my financial and health records. I hereby authorize Birmingham Vision Care to release information to my insurance company, other doctors, or to a pharmacy as is necessary to care for my visual needs.

Print Name(s) who we can release information to :

_____

→ Patients under the age of 18 years old

The undersigned parent/legal guardian of _____ (child's name), does hereby empower and grant to Birmingham Vision Care 248-539-4800 the right to consent permission of any examination, medical diagnosis, tests, treatment, including Optomap to be rendered for my child/ward. I do hereby indemnify and hold harmless to Birmingham Vision Care who act in reliance upon this authorization.

_____

Print Parent/ Legal Guardian Name Signature Date

I understand the above named person(s) provide my health benefits and may be contacted concerning my financial and health records. I have read and agree to follow the policies and my responsibilities as outlined above.

_____

Print Patient Name/ Responsible Party Signature
Date