Richens Eye

ACKNOWLEDGMENT AND CONSENT

Health History

I understand that providing incorrect information can be dangerous to my health. I certify that I have read, understood, and completed the health history questionnaire fully and accurately to the best of my ability.

Release of Information

I understand that the doctor may need to call to collaborate with other healthcare providers and/or third-party payers in order to provide the best standard of care for me. I authorize the doctor to release any necessary information, including the diagnosis and the records of any treatment or exam rendered to me or my dependent, during the period of vision care to third-party payers and/or other health care providers related to my care.

Financial Policies

I understand that this office offers the service of accepting and filing most vision and or medical insurance claims for patients. I understand that the office staff, as a courtesy, will research any applicable benefits for me and assist me in understanding my insurance policies. I understand that the Richens Eye will make every effort to give accurate estimates of what I will owe for each visit, but that they cannot guarantee exactly what my insurance will pay. I understand that if I have vision and or medical insurance, this is a contract between the insurance company and myself and is ultimately my responsibility, not Richens Eyes responsibility.

I understand that I am expected to pay what is due for my treatment when I receive it. I understand that when a child of divorced parents is seen, whichever parent accompanies the child to their visit will be expected to pay. I understand that if any balance remains after my insurance company has paid a claim, I will receive a statement and I am expected to pay in full within 15 days of receiving this statement.

I agree to be responsible for timely payment for all services rendered on my behalf or my dependents. I agree to be ultimately responsible for all charges on my account which have been applied in accordance with the established office policy.

I understand that if my account remains unpaid, it may be transferred to a collections agency. I understand that my account will be charged a $50.00 fee for any dishonored check and that I am expected to pick up the check and pay the balance and subsequent late fees in cash.

Any agreement that these policies may be superseded by a written and signed agreement of an alternate policy specific to my account.

Rescheduling/Cancellation Policies

I understand that if I need to reschedule an appointment, or cannot make it to an appointment, I must give 48 hours notice. If I do not give adequate notice, my account will be charged a $50.00 cancellation fee.

Privacy Practices

_____ I acknowledge receipt of Privacy Practices Notice (HIPAA) Available Upon Request.
(Initial)

Print patient name (or parent/guardian if minor): _____ Date: _____

Signature of patient (or parent/guardian if minor): _____ Date: _____

Office Information:
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St. George, Utah 84770
435.986.2020