2450 NE Mary Rose Place, Suite 110
Bend, Oregon 97701
541-318-8388 fax: 541-318-7145

FINANCIAL POLICY / AGREEMENT

Infocus Eye Care is committed to providing our patients with the best possible care and service to you. Understanding our financial policy is an essential element of your care and treatment in our office.

- Proper identification will be required at time of service. Please bring a picture ID, such as driverôs license and your current insurance card with visible identification numbers. Identifying you properly is for your protection against insurance fraud. If you cannot produce proper ID you may be asked to reschedule your appointment for when you can produce ID, or you may pay in full at the time of service.
- Payment accepted by cash, check, major credit cards and Care Credit (for balances greater than $1000).
- There will be a $25.00 charge for returned checks.
- We will look to the accompanying adult for payment of all service rendered on a minor patient under 18 years of age.
- **Insurance** ï As a courtesy, we will bill your primary and secondary insurance companies that you provide at the time you receive care.
- Payment for co-pays is due at the time of service.
- Insurance reimbursement is a result of a contract between you and your insurance carrier. If they do not pay within a 60 day period, we will look to you for payment. Infocus will refund any overpayment made by you once the insurance pays. Payment for services remaining on account balances after the health insurance pays or denies, or non-covered services will be your responsibility. Payment is due in full upon receipt of a statement from our office.
- **Verification of benefits is the patient's responsibility as only the insurance company can guarantee your coverage. Infocus Eye Care is not contracted with VSP, EyeMed or any Vision Benefit only plan. Payment in full is expected at the time of your visit if you have Vision benefit only plan.**
- If your account balance is not paid in full within 3 months from date care is received, your account will be subject to normal collection procedures. Account balances turned over to a collection agency will result in a $50.00 fee.
- **Credit accounts** are extended as a courtesy to our patients. We reserve the right to revoke the privilege if the account is not maintained in a current status, or other circumstances arise wherein the owner/manager deems a creditor/debtor relationship is inappropriate. Determinations will be made on an individual basis.
- **Optical purchases -** a deposit will be required at time of order, and payment in full is expected at the time of dispense on all hardware items, glasses/contact lenses; patient balance is required at time of dispense for insurance plans with which we participate. Infocus will refund any overpayment made by you once the insurance pays. Payment for services remaining on account balances after the health insurance pays or denies, or non-covered services will be your responsibility. Payment is due upon receipt of a statement from our office.
- **Surgery -** Your estimated portion for planned and agreed upon surgical procedure(s) is due prior to the surgery date. This includes any premium lens and/or service. LASIK fees are due in full prior to the surgery. If a LASIK benefit is available to you through your insurance plan we will still require payment in full prior to surgery. Infocus will refund any over payment made once the insurance pays.

I have read and understand the above financial policy of Infocus Eye Care. Copy has been provided to me.

_____
Name of responsible party

_____ _____
Signature of responsible party Date

If you have any questions concerning Infocus Eye Care Financial Policy please call the Billing Department directly at 541-749-4991. Thank you for choosing Infocus Eye Care.

Revised 3-14-18

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Infocus eye care
cataract • lasik • vision

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that Infocus Eye Care, from here on referred to as Infocus, will use and disclose health information about me.

My health information may include information both created by and received by Infocus, may be in the form of written or electronic records or spoken words and may include information about my health history, health status, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

I also understand that I have the right to receive and review a written description of how Infocus will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of Infocus and my rights regarding my health information.

I understand that the **Notice of Privacy Practices** may be revised from time to time, and that I am entitled to receive a current version of Infocusô**Notice of Privacy Practices**. I also understand that a copy or summary of the most current version of Infocusô**Notice of Privacy Practices** in effect will be posted in the walking / reception area and available on the website, if applicable.

I understand that I have the 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 Infocus 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 been offered a copy of the **Notice of Privacy Practices.**

Patientôs Name _____
Please Print

Patientôs Signature _____ Date_____

Witness _____ Date_____