

NOTICE OF BILLING PRACTICES:

THIS NOTICE DESCRIBES OUR BILLING PRACTICES, PLEASE REVIEW IT CAREFULLY.

At Shasta Eye Group, you can expect to receive medical services in a professional and caring manner. We are committed to providing you with the highest level of service and quality care. In return, it is your responsibility to provide your insurance information. Please have your photo identification and current insurance information available at your visit to ensure that your claim can be processed promptly.

1. APPOINTMENTS: We request that you keep scheduled appointments and arrive at the appointed time. If you are unable to keep your appointment, please give at least 48 hours notice. [Cancellations of less than 24 hours prior to your appointment, or a No-Show for your appointment, will result in a minimum \$35 fee per patient, excluding Medicaid patients.] We reserve the right to not make additional routine appointments for you should you have any remaining balance for previous treatment you received with our offices. Additionally, any outstanding balance will need to be addressed before checking in for an appointment.
2. CO-PAYS: According to your insurance contract, you are obligated to pay any co-pay (a small fixed amount required by your health insurer), deductible (amount you are liable before your health insurer will make payment), or co-insurance (percentage of total cost of medical expenses after your deductible has been reached) due at the time of service. IF you are unable to pay the co-pay at the time of service, we retain the right to cancel or reschedule your appointment to a time when you are prepared to pay your co-pay. Furthermore, if your appointment is kept without payment of the co-pay at the time of service, we retain the right to levy an administrative charge of \$10 to your account in order to defray the cost of securing the co-pay.
3. PRESCRIPTION REFILLS/FORMS: Please request any prescription refills and present any forms that need to be completed at the start of your examination. At that time, we have full access to your complete record and can fulfill your request. We reserve the right to charge the state allowable amount for filling out and completing forms or attorney requests for your various needs (ie, SSI, disability, etc.).
4. EYE EXAMS & GLASSES: This policy will only apply if you need to purchase eyeglasses and/or contact lenses. You may request a copy of the full policy/procedure for your records.
 - One Rx check within 90 days of original exam
 - One Rx remake within 90 days of original order date
 - One lens remake is allowed during 1 year warranty period
 - One frame restyle allowed within 30 days including a fee of \$50
 - Frames carry a manufacturer warranty against defects for 1 year
 - All eyewear and/or contact lens orders must be paid in full prior to submitting to vendor
 - All sales are final
5. REFERRALS: If your insurance plan requires a referral, the referral must be presented before seeing a physician. If you do not have the required referral, we reserve the right to reschedule your appointment or you will have to be willing to be responsible for the entire cost of the examination. You will be presented with a waiver acknowledging your acceptance as self-pay, and payment will need to be made at the time of service.
6. RETURNED CHECKS: Any payment made by check that does not clear our bank account will result in a fee for insufficient funds. Our fee for insufficient funds is \$25 and will be added to your account for each bounced check.

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7. OTHER INSURANCE: I understand that Shasta Eye Group participates with multiple insurance plans and that not all Doctors in the Practice participate with all plans or products within the plans. I understand that it is my responsibility to verify with my insurance carrier that my physician currently participates with my plan. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Shasta Eye Group if I belong to a plan with which Shasta Eye Group does not participate.
8. NON-COVERED SERVICES: I understand that Shasta Eye Group contracts with health care service plans related only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. **Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care plan service plan furnishes to the patient (i.e. refraction, contact lens fittings) and treatment or tests not authorized by the health care service plan.** The undersigned agrees to cooperate with Shasta Eye Group to obtain necessary health care service plan authorizations.
9. FINANCIAL AGREEMENT: I agree that in return for the services provided to me by Shasta Eye Group, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Shasta Eye Group for payment. I understand and agree that if my account is delinquent and sent to collections, I may be charged up to 35% in administrative fees. If the account is sent to an attorney to assist with collections, I agree to pay collection expenses and reasonable attorney fees. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Shasta Eye Group. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Shasta Eye Group. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill. I further understand and agree that if I ignore statements of attempts to collect past due amounts, I may have my ability to schedule appointments and/or receive future services from Shasta Eye Group limited including possible dismissal as a patient from the practice.
10. PATIENT STATEMENTS: At Shasta Eye Group, all accounts are payable within 30 days after you receive your first statement. Credit is extended as a courtesy, and arrangements will be based on demonstrated needs. Payments keep your account current only when arrangements have been made. Please call customer service to set up payment arrangements. As a result of costs associated with sending statements, Shasta Eye Group does not send statements to patients for balances under \$20. Billing statements are suppressed until the patient's balance becomes \$20 or more in patient responsibility. As a result, you may receive a statement long after your last appointment or may be asked to pay small balances when presenting for an appointment without having received a statement. Patients should remit small balances owed to Shasta Eye Group upon receipt of their explanation of benefits from their insurance.
11. PATIENT DISMISSAL: I agree and understand that Shasta Eye Group may initiate separation and/or dismissal of me as a patient of the practice for any of the following non-exclusive reasons:
- (a) Disruptive, aggressive, violent, and/or threatening behavior towards physicians, staff, and/or other patients;
 - (b) Repeated failure to attend scheduled appointments;
 - (c) Non-compliance with physician instructions and recommended treatment and/or other erosion of physician/patient relationship; and
 - (d) Non-payment of past due amounts and/or failure to pay any past due amounts as agreed in any payment arrangement you entered with Shasta Eye Group. Please note, making payments that are less than an agreed amount per a payment arrangement will be considered and treated as

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non-payment for purposes of this provision.

Patients who are dismissed from the practice will be notified in writing and will be given 30 days to find alternative vision care. Appointments for emergency visits will be allowed during the 30 days but payment of an emergency visit will be collected at check-in with any additional amounts due collected at check-out.

The physicians and staff at Shasta Eye Group appreciate your confidence in allowing us to participate in your eye care.

Your signature indicates that you have read, understand and agree to the financial responsibilities policies and procedures of our office.

PATIENT'S NAME: _____

PATIENT'S DATE OF BIRTH: _____

PATIENT/GUARDIAN SIGNATURE: _____

DATE: _____ TIME: _____

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