Family Eye Care of the Carolinas
SIGNATURE PAGE

PAYMENT IS EXPECTED at time of service for Co-Payments and non-covered services.
There is a $20 billing statement fee for nonpayment at time services are rendered.

Statement of Financial Responsibility

Family Eye Care of the Carolinas does not bill other parties such as financially responsible parents or employers. When a minor is presented for care, the person present with minor is responsible for payment at time of service. I understand the services provided today may or may not be covered by my health plan**. If my health plan deems these services are non-covered or not medically necessary, then I understand that I am financially responsible for any non-covered/non-medically necessary services and/or supplies provided.**
I understand that I am financially responsible and consent to serve as a guarantor of payment for all services rendered to the patient listed. Although FECC may file insurance claims as a courtesy, I understand that FECC cannot accept responsibility for collecting insurance payments or for negotiating a disputed claim. Insurance reimbursement is a contract between the patient and the insurance carrier. Insurance company Usual, Customary and Reasonable (UCR) allowable are established without regard to FECC's cost and charge. I understand that I am responsible for the difference between the insurance payment and FECC charges except in circumstances where FECC has a contractual agreement with a health plan that prohibits such collection of payment from the patient and/or subscriber. Should this account be referred to an attorney or collection agency, attorney's fees and or collection expenses shall be payable by me in addition to other amount due,

I understand that appointments missed or not cancelled with at least 24 hours notice will be subject to a $40 fee. This fee is the sole responsibility of the patient/guardian and not payable by insurance.

Patient Name _____

I have read and agree to understand this policy _____ Date_____
Signature of patient/ legal guardian

Authorization to Release Information AND Pay Benefits to Family Eye Care of the Carolinas

I hereby authorize the physician designated to release information required in the course of my examination and treatment and hereby assign payment directly to the designated physician for my medical/surgical services provided. I am fully responsible for any balance due to this company. I acknowledge Family Eye Care of the Carolinas participates in E-Prescribing and authorize the physician and/or staff to submit and transmit any prescription information via the internet system SureScript. I also agree to allow the physician or a member of his staff to identify me by name in the lobby of this practice and also to contact any of the telephone numbers to confirm appointment or deliver medical information.

Signature of Patient (or legal guardian) _____ Date_____

Notice of Privacy Act (HIPPA)

My signature below indicates that I have reviewed Family Eye Care of the Carolinas Notice of Privacy Practices.

_____ _____ _____
Your Signature Patients Printed Name Date

If there is someone who should receive your Personal Protected Health Information other than yourself, Family Medical Doctor, or referring physician, please list below. Individuals other than birth parents/self (step-parents, spouse, extended family, caretakers…) must be listed or information cannot be shared.

_____ _____ _____ _____
Name Relationship Name Relationship

_____ _____ _____ _____
Name Relationship Name Relationship