New England College of Optometry

CENTER FOR EYE CARE

ACKNOWLEDGMENT OF PRIVACY PRACTICES AND CONSENT TO TREATMENT

I understand that I am establishing eye care at the NECO Center for Eye Care and that I will be examined and receive care based on my diagnosis and goals. I understand that I have the right to have any questions regarding my treatment answered by the clinician and the NECO Center for Eye Care has the right to refuse care.

PAYMENT POLICIES

OUR RESPONSIBILITY

- We aim for transparency and communication regarding the cost of your eye care. Please ask for your benefit quote for specific information regarding your insurance benefits.
- We will bill Vision, Medical, Worker's Compensation, and/or Automobile Insurance for your visits. We reserve the right to bill a patient's medical insurance if the situation warrants.

PATIENT RESPONSIBILITY

- You must provide us with complete details regarding your insurance information including the name of insurer, member ID and/or claim number and of any insurance changes during your care. If this information is not complete, you will be responsible for the cost of the visit.
- All copayments must be made at the time of visit. Any deductible and coinsurance balances must be paid after claims are processed by your insurance company.
- After treatment is completed, account balances are due within 30 days of final claims processing. NECO Center for Eye Care reserves the right to seek external collections on outstanding balances.

We are sensitive to the financial needs of our patients. Please communicate with clinical and administrative staff if cost is a barrier to your care. We will work with you to create a feasible payment arrangement.

If you disagree with the way in which your insurance company has processed your claims, we ask that you contact them directly. We are happy to answer any other questions you have.

CANCELLATION POLICY

Out of mutual respect for the time of our clinical staff, your time, and that of all of our patients, we ask that you provide us with at least 24 hour notice of appointment cancellations. Chronic no-shows and last- minute cancellations may result in penalties.

CONSENT TO TREATMENT AND PAYMENT POLICY

I consent to all the policies stated above. FURTHERMORE, I authorize all insurance payments to be released to NECO Center for Eye Care for services rendered and understand that any outstanding balance is my responsibility.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided access or given a copy of the Notice of Privacy Practices (NPP) for the NECO Center for Eye Care. I understand that the NPP is available on the NECO Center for Eye Care at any time. I understand my medical records are confidential. By signing this consent form, I authorize NECO Center for Eye Care to use and disclose my protected medical information for treatment, payment, utilization review, quality assurance activities or health care operations. I can revoke or restrict this authorization at any time by written request. I assign all medical benefits including the major medical I am entitled to NECO Center for Eye care. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as original.

Signature:_____ **Date:** _____