Kueber Eye Care 1011 1st Street East Park Rapids, MN 56470 218-732-8535

OUR FINANCIAL POLICY

We will gladly submit billing information to your insurance company on your behalf. Copays and payment for non-covered services are due on the date of service. We accept cash, check, credit card (Visa, Mastercard, Discover, American Express) or Care Credit.

Financial Repsonsibility:

- I understand that all co-pays and payment for non-covered services are due on the date of service
- I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 1.5% per month.
- I understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any and all fees generated as a result of collection efforts.

Consent to Treat

- I hereby authorize and consent to the performance of the following that my physician and I agree are necessary:
    - Examinations
    - Diagnostic Procedures
    - Treatments
- I understand that no guarantee has been made as to the results of the care, treatment, and/or medications given to me
- This consent shall remain in effect until I choose to revoke it in writing.

Assignment of Insurance Benefits:

- Kueber Eye Care will work for and with you in an effort to obtain proper reimbursement from your insurance plan.
- I assign all applicable health insurance benefits to which I and/or my dependents are entitled to Kueber Eye Care.
- I certify that the health insurance information I have provided is accurate and that I am responsible for keeping it updated.
- I agree to immediately remit to Kueber Eye Care any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to Kueber Eye Care.
- I understand that some third-party payers may require that my medical information, including copies of treatment notes, be submitted along with requests for payment.
- I hereby authorize Kueber Eye Care to release all medical information necessary to secure payment from my insurance company, and I authorize the use of this signature on all related submissions.
- I understand that this authorization shall remain valid without expiration unless expressly revoked by me in writing.

INSURANCE AUTHORIZATION AND RELEASE:

- I authorize the release of any information including records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.
- I authorize and direct any holder of medical information or documentation to include city, county and state accident reports about me or my dependent to release such information to Kueber Eye Care, its billing agents and/or any other payers or insurers as may be appropriate to determine any benefits payable for these or any other medical services provided to me or my dependent by Kueber Eye Care
- I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.
- I understand that I am responsible for services not covered by insurance.

_____ _____

Patient Signature Date

_____ _____

Representative Signature Date

(A representative is someone other than the patient who is responsible for their medical and/or financial affairs.)

A copy of this form is valid as an original.