



1011 W Fulton Market
Chicago, IL 60607
Phone (312) 226-2020

Billing and Financial Policies

Insurance Authorization and Assignment: I request that payment of authorized private insurance company benefits, Medicare and Medicaid services or other applicable benefits be paid on my behalf to Eyes on Fulton for any furnished services. I authorize Eyes on Fulton to release any medical or other information about me to any private insurance company, Medicare or Medicaid or other company and its agents, which might provide coverage to me.

All Services are the Responsibility of the Patient: Eyes on Fulton will gladly bill your primary insurance. I understand that insurance benefits must be determined prior to my exam. If I become aware of insurance coverage after services have been rendered, I agree to personally submit the claim to my insurance company for reimbursement. I understand that when my insurance company requires a referral from my primary-care physician, and I do not furnish the correct referral at the time of service, I will be responsible for payment if my insurance company refuses by claim. I also understand and acknowledge that I am financially responsible for non-covered services and unpaid balance over 45 days past due.

Payments, Co-pays and Deductibles are Due at the Time of Service: I understand that not all services and materials may be covered by my insurance or may exceed benefits or coverage. I agree to pay all payments, co-pays and deductibles at the time of service for all services and materials.

Returned Checks: There is a \$25.00 fee for any check returned by the bank. This fee will be added to the unpaid balance and must be paid by cash or credit card.

Patient Name: _____ (please print)
Or Responsible party (if not patient)

Signature: _____ Date: _____

ACKNOWLEDGEMENT RECEIPT

By initialing below, I acknowledge I have been offered a copy of Eyes on Fulton's Notice of private practices.

_____ Yes, I would like a copy of Eyes on Fulton's Notice of Privacy Practices.

_____ No, I do not wish to receive a copy of Eyes on Fulton's Notice of Privacy Practices

ANNUAL CONTACT LENS EXAM

By law, a contact lens prescription is valid for only one year. All patients are required to come in for an annual contact lens exam. This is necessary to assure that the patient's eyes are healthy and the contact lenses are still fitting well. Contact lens prescriptions cannot be renewed without an annual exam. Contact lens exams have a separate charge that is **NOT** included in your medical/eye health exam. **Dispensing of trial contact lenses may only be at the time of the original examination and scheduled follow-up visits when a change is required. A contact lens trial will not be dispensed at other times.** Any patient who is changing lens brands must have a new fitting and there may be an additional fitting charge. Follow up visits are at no cost for **90 days** from the time of initial exam. Please order your supply of contacts at least one week prior to running out of your contact lenses.

I have read and understood the above statements.

Signature: _____