BEAUFORT VISION CLINIC
A MEMBER OF VISION SOURCE

INSIGHT OPTOMETRIC SERVICES, P.A.

Notice of Privacy Practices

I understand that Insight Optometric Services d.b.a. Beaufort Vision Clinic will not sell my private information, nor will they release it without my permission. I also understand that I have the right to review my records and receive an in-depth copy of them should I make a formal request. I also understand that the full HIPAA Privacy Policy is available to me, should I request it.

INITIAL: _____

Financial Agreement

In order to keep fees as low as possible, payment in full is due at the time exam services, treatment, or materials are rendered and/or ordered. This includes all copayments set forth by your medical or vision insurance plan guidelines. Any service or treatment requiring the Doctor's time is non-refundable. We accept cash, checks, all major Credit Cards, and Care Credit.

It is important to understand that you are ultimately responsible for the bill if your insurance claim is denied. If your insurance claim is not paid within 90 days from the date of service, we request that you pay your account in full and take the matter up with your insurance company. We verify and file insurance at our own expense as a courtesy to our patients.

INITIAL: _____

Notice of Non-Coverage for Non-Medicare Patients

Medical insurance is typically required when you have any condition or symptoms related to an eye health problem. Generally, they do not cover routine exams. A refraction is performed to determine your eyeglass prescription. Medical insurance companies consider this service a "non-covered" service. **The estimated cost for a refraction is $30.00**. Please keep in mind that Refraction = Eyeglass Prescription.

☐ Refraction Wanted ☐ Refraction Not Wanted INITIAL: _____

Authorization

I certify that I have read, understand and answered the above questions accurately and to the best of my knowledge. I understand that providing inaccurate information can be detrimental to my health. I hereby authorize Insight Optometric Services to release information, including diagnosis and records of treatment or examination rendered to me or my dependents, to healthcare practitioners and third-party payers. I understand my insurance carrier may pay less than the actual bill for services. I agree to accept responsibility for payment of all services rendered on behalf of myself or my dependants. I understand that after Insight Optometric Services settles with my insurance carrier, any unpaid balance that remains on my account after 90 days will be turned over to collections *(unless previous arrangements have been made between management and patient)*.

PATIENT NAME (PLEASE PRINT): _____

SIGNATURE: _____ DATE: _____