Financial Policy & HIPAA Privacy

Insurance Submission Policies

We will bill insurance claims to primary and secondary carriers as a courtesy to our patients. It is your responsibility to provide us with the most current insurance information. You must also have a referral, when requested, before being seen by our office. Payment in full will be required if the necessary referral was not obtained. **Payment of copays, deductibles, and non-covered options are due at the time of service.**

Parents/Guardians requesting treatment for a minor will be responsible for the payment on the account. **Your insurance policy is a contract between you and the company you have chosen, therefore, it is your responsibility to know what your benefits are.** We will attempt to verify benefits before the time of service; however all insurance companies have a disclaimer that the information or authorization obtained may not be accurate and is subject to review at the time the claim is processed. **You may be billed in the event that your insurance plan denies a claim or does not pay in a timely manner. All fees are ultimately your responsibility.**

Collections and Returned Check Fees

I understand if I have an unpaid balance to Keelan Eye Care and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for the reimbursement of the fee of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs and expenses, including reasonable collection and attorney's fees incurred during collection efforts.

In order for Keelan Eye Care or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Keelan Eye Care and the designated external collection agency are authorized to (**1**) contact me by telephone at the telephone number I am providing, including wireless telephone numbers, which could result in charges to me, (**2**) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (**3**) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

There is a $30 charge on all returned checks. Accounts that do not resolve check issues within 14 days of notification will be sent to collections and assessed a 35% administrative fee in addition to the $30 check fee.

HIPAA Privacy Acknowledgement

By signing the receipt of notice of privacy practice; I acknowledge and agree that I have received a copy of the Notice of Privacy Practices for review and to keep for my records on the date identified below. I understand that the location may use and disclose necessary personal health information to another party to permit its administrative duties, provide me with the eye care services and products, process my vision benefit claims and communicate with me regarding vision care services provided by the location. **I authorize this location to submit my vision benefits claims to my plan sponsor or health insurance to receive reimbursement directly for services I have received.**

I acknowledge that I am aware that my information may be shared with Keelan Eye Care and other parties as part of an examination reminder service. **I can be assured this location does not sell my personal health information of any kind to a third party for such parties' own use other than what has been indicated above.**

Print Patient Name: _____ Date: _____

Patient Signature: _____