Financial Statement ● Insurance Billing ● HIPAA

Contact Lens Evaluation & Fitting:
Contact lenses are medical devices regulated by the FDA. Your optometrist is required to evaluate the health of your eyes and the fit of your contacts every year in order to determine the best prescription for your eyes. For this service, contact lens patients will be charged a contact lens fitting and evaluation fee. Most vision and insurance plans require that this be charged separately from the exam and many insurances do not cover this fee.

Patient Responsibilities & Agreement:
Your insurance coverage is a contract between you and your insurance company. You are ultimately responsible for payment of your account. We will do our best to help you verify your benefits. We will also bill your insurance company if we are in network. Finance charges will be applied to accounts overdue of 90 days.

Medical Insurance & Vision Plans:
Saratoga Vision is committed to caring for our patient's complete ocular health. We provide both, routine vision exams, as well as diagnosis and treatment of eye conditions. Routine vision exams where there is no medical complaint with a diagnosis, will be filed to your vision plan if applicable. If you have a medical complaint with diagnosis, your exam will no longer be considered routine. In these instances, we are required to bill your examination to your medical insurance. Please give all insurance information to check-in upon arrival. It is your responsibility to have all insurance cards at the time of your visit.

I understand it is my responsibility to know:

- The name of my insurance company
- My benefits (what is covered and not) and the amounts of my co-pays and deductibles
- If a prior authorization is required

I understand that any amounts not covered by my insurance for services received are my financial responsibility. I understand that all co-pays are due at the time of my appointment. I authorize the release of any medical information necessary to process claims and authorize my insurance company to make payments directly to Saratoga Vision.

Print Patient Name	Signature of Patient or Parent/Guardian	Date

Acknowledgement of Receipt of Privacy Practices

Privacy Official: Kathy Mapes Kathy@SaratogaVision.com

A copy is available for review of Saratoga Vision's NOTICE OF PRIVACY PRACTICES. I hereby acknowledge having received a copy to review. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this notice should it be amended, modified or changed in any way.

Print Patient Name	Signature of Patient or Parent/Guardian	Date

Office Use Only

___Patient did not understand due to language barrier

___Patient was offered Copy of HIPPA but refused to sign

Updated 7/1/2016