Shalane Perlowsky O.D. PC

3345 Virginia Beach Blvd. Virginia Beach, VA 23452 (757) 463-1508

INSURANCE AUTHORIZATION AND BINDING FINANCIAL AGREEMENT

Providing the best possible eye care involves a mutual understanding between patient and provider. Should you have any questions regarding the following policies, please ask for clarification. Our professional services are rendered to you, not your insurance company. Ultimately, payment for our services is YOUR RESPONSIBILITY.

I authorize Shalane Perlowsky O.D. PC to release any information regarding my care to expedite claims or for records transfer should such events be required.

I hereby authorize Shalane Perlowsky O.D. PC to bill my insurance company for services provided to me and with payment made directly to the providing doctor's office and that such authorization is valid until written notice is provided to cancel that authorization.

While Shalane Perlowsky O.D. PC makes considerable effort to verify my insurance coverage, benefits, and cost shares, I understand that such information is NOT an official or legally binding estimation of my out-of-pocket expenses. Ultimately, my final cost share is dependent on the decision of my insurance carrier. I UNDERSTAND THAT ANY COPAY ESTIMATES GIVEN TO ME PRIOR TO MY EXAMINATION MAY TURN OUT TO BE DIFFERENT FROM THE FINAL DECISION OF MY INSURANCE CARRIER AND I AGREE THAT I AM DIRECTLY AND FULLY RESPONSIBLE TO SHALANE PERLOWSKY O.D. PC FOR PAYMENT OF ALL CHARGES, INCLUDING ANY AMOUNT IN EXCESS OF PREVIOUS COPAY ESTIMATES. I realize that if my insurance company fails to pay its anticipated balance in full or payment is not made within 60 days it is my responsibility to pay the doctor's bill and that I will pay collection fees, attorney's fees, court costs, etc. for the purpose of collection on delinquent accounts.

In the event that I receive payment from my insurance company for services provided in this office, I agree to endorse any received payment to the doctor's office.

I understand there may be medical findings during the course of my exam. I understand it is a VIOLATION of Shalane Perlowsky O.D. PC's provider agreement with my insurance to bill such medically related services to my vision wellness plan. In this event, my medical insurance will be billed and I understand I will be responsible for any applicable copays, cost-shares, and/or deductibles as per my agreement with my insurance company. I also understand that Shalane Perlowsky O.D. PC will not neglect medical findings in order to bill my vision wellness plan, as that would put Shalane Perlowsky O.D. PC in direct conflict with its ethical obligations to the Virginia Board of Optometry.

I understand there is a $30 fee for all returned checks.

I understand and agree to all statements made herein and understand this is a legally binding agreement.

Patient/Guardian Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

By signing below you attest that you have received, reviewed, and understood this practice's privacy policy and the rights to privacy that you are afforded by federal legislation (HIPAA Privacy Act). The privacy policy outlines how your information is shared only for the purpose of performing service or collecting payment. These policies are subject to change or modification without notice.

Patient/Guardian Signature: _____ Date: _____