



Ruth A. Weber, O.D.

100 W. Main Street Omro, WI 54963

1081B W. Fond du Lac Street Ripon, WI 54971

**HIPAA-NOTICE OF PRIVACY PRACTICE**

I acknowledge that I have ( **received / been offered** ) a copy of the Notice of Privacy Practices for Weber Eye Care. This notice describes how this office may use and disclose my protected health information, and rights I may have regarding my protected health information. The HIPAA privacy regulations require that signed consent forms be retained for a period of seven years.

Print Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature or Responsible Adult

--Other authorized person on account: Name and Address  
\_\_\_\_\_

**FINANCIAL POLICY**

Thank you for choosing Weber Eye Care for your eye care needs. As part of our service to you, we try to contain the ever-rising cost of health care. In an effort to do this, we have implemented the following Financial Policy. We require all patients to read and sign our Financial Policy prior to treatment. If you have any questions, please let us know. We will be happy to discuss our policy with you. **If you do not provide proof of insurance at time of service the balance is your responsibility. If provided within 5 days we will gladly submit the claim on your behalf. Our office policy is that our patients contact their insurance companies to find out what the benefits are (to insure that the maximum benefits are received).**

--**Medicare Patients:** We submit and accept assignment on all Medicare claims. By accepting assignment on your claim, we have agreed to reduce our fee down to the Medicare allowed amount. **If your Medicare deductible has been met, Medicare then pays 80% of its allowed amount.** If you have supplemental insurance, we will submit the 20% balance to this carrier. If your supplement does not pay the balance within 30 days of claim submission, you will be responsible for payment. If you do not have supplemental insurance, we will bill you personally for the balance. **All balances are due and payable upon receipt.**

--**Private Insurance:** We submit claims to all primary and secondary insurance carriers. Wisconsin law dictates that health insurance carriers must process claims within 30 days of claim submission. If your carrier has not paid on your claim within 30 days, you will be responsible for payment. Please remember that your insurance coverage is a contract between you and your carrier. For your convenience, we are handling the submission of the claims to your carrier, but we are not a party to your insurance contract. You, the insured, are responsible for payment on any claims that are 1) denied; 2) unpaid due to deductible; 3) partially paid; 4) specifically partially paid due to the carrier's arbitrary determination of "usual and customary" rates; or 5) any claims for contact lens examinations that are specifically not covered by your insurance company. **All balances are due and payable upon receipt.**

--**No Insurance:** For all services not covered by insurance, **full payment is due at time of service.** We accept CASH, CHECK, VISA/MASTERCARD, DISCOVER and CARE CREDIT. Extended payment plans may be approved only under extenuating circumstances.

--**Minor Patients:** Parents should ideally accompany minor patients to any medical appointment. For unaccompanied minors, non-emergency treatment may be denied unless full insurance information is provided or prior arrangements for full payment at time of service have been made.

--**REFRACTIONS:** Medicare and all health insurance carriers, **require** the refraction portion of your examination fee to be billed separately from the comprehensive portion. Medicare **has never covered, and will not cover** this fee because they consider the refraction a "**ROUTINE NON-COVERED SERVICE**". **Some** other health insurance carriers may not cover this examination fee either. In most cases, our patients must pay for the cost of this important service.

--**Optical Purchases:** **ALL ORDERS REQUIRE A 50% DEPOSIT AT THE TIME OF PURCHASE.** The deposit will be forfeited if eyewear is not picked up within 60 days of notification or if the order is canceled (to cover lab restocking fees). Your balance will be due at the time of pick up. All eyeglass lens orders will have a 60 day satisfaction guarantee. If you are unable to adapt, we will remake your lenses at no charge within that 60 day period, anything after the 60 days, you will be responsible for the charges. **First time progressive lens wearers will need to try out their new lenses for at least 14 days before determining if they are unable to adapt,** but must still stay under the 60 day period for Weber Eye Care to remake at no charge. You will be refunded the difference in price if the newer lens is less expensive than the previous lens, minus a \$50.00 non-refundable lab fee.

**Returned checks:** All checks that are returned for insufficient funds will be charged a NSF fee.

**Collections Agency Placement Policy:** You are financially responsible for the timely payment of your outstanding bill per out payment policies. You will be responsible for any and all collection agency fees up to **30%** of the amount placed with the collection agency. In the event we seek legal action for collection on your account, you will also be responsible for any and all fees associated with court costs, garnishments, and/or attorney fees.

I have read the Financial Policy and understand its contents. I agree to abide by the policy for all services provided by Weber Eye Care.

Date: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature or Responsible Adult