FIRSTEYECARE
KILLEEN

Financial Agreement

Signing this paper is required before any services are performed or products purchased.

I understand that First Eye Care Killeen is a doctor's office - not my insurance company.

I understand that First Eye Care Killeen will help facilitate my insurance transaction, but that ultimately it is my responsibility to know the terms and conditions of my medical insurance coverage or vision plan coverage.

I understand that vision plans (example: VSP, EyeMed, Avesis, Davis Vision, Superior Vision, NVA) only provide coverage for routine eye examinations and discounts on glasses and contacts. I also understand that vision plans do not cover for any medical eye problems I may be having.

I understand that depending on the eye problem I am having and the doctor's assessment of that problem, my medical insurance and/or my vision plan may be filed today. Medical eye problems are filed to my medical insurance. Routine care and refractive prescription problems are filed to my vision plan.

I understand that deductibles, co-payments, and co-insurance must be collected from me by First Eye Care Killeen as required by my insurance company or by the law. Those amounts will be collected today at the time of service.

I understand that First Eye Care Killeen will make only reasonable efforts to process my claim for services rendered and/or products ordered on my behalf.

I authorize First Eye Care Killeen to release any personal or medical information to any medical insurance, vision plan company or its agents that is necessary for determining my benefits or collecting payment for services rendered, and I authorize payment from my insurance to be made to First Eye Care Killeen for services and products I receive.

I understand that if for any reason payment for provided services and/or products is denied to First Eye Care Killeen by my third-party insurance, I am responsible for paying for these provided services and/or products. I understand that in this occurrence, I will be billed for the services and/or products that were denied by insurance and payment will be expected within 30 days of receipt of this bill.

I understand that doctor's services are not refundable under any circumstance once they are received. Products ordered from First Eye Care Killeen, including glasses and contact lenses, are not refundable and are only eligible for exchange credit.

I understand that payment may be made to First Eye Care Killeen with cash, Mastercard, Visa, American Express, Discover, personal check, Care Credit, Health Savings Account or Flexible Spending Account. No temporary checks will be accepted. Out-of-state checks will be accepted only with prior management approval.

I understand that writing a personal check with insufficient funds is check fraud, and that all matters involving check fraud will be referred to the Bell County District Attorney's office for review and collection. A $40.00 returned check fee will be assessed to me.

SIGNATURE: _____ DATE: _____

Killeen Eye Associates PA
3124 E. Central Texas Expwy
Killeen, TX 76543
Phone: 254-690-4733
Fax: 254-690-6728

Notice Of Privacy Practices Acknowledgement

The law requires that Killeen Eye Associates PA make efforts to inform you of your rights related to your personal health information. The **Notice of Privacy Practices** of Killeen Eye Associates PA is available by request from our representatives and on our website at www.firsteyecarectx.com.

I acknowledge that I have read or was given the opportunity to read the **Notice of Privacy Practices** prior to any services offered.

_____ _____
Patient Signature Date

If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you are attesting that you have legal authority to make medical decisions for the minor.

_____ _____ _____
Parent or Representative Signature Relationship to Patient Date

You can choose to authorize access to your personal health information to other people by listing their names below.

I authorize Killeen Eye Associates PA to release my personal health information to the following individuals:

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient