NOTICE TO ALL PATIENTS USING INSURANCE:

Proof of insurance is to be presented at time of exam. We do not retro bill claims.

Major Medical Insurance Provider:____

Vision Service Provider:____

Primary Insured's Full Name:____

Primary Insured's Date of Birth:____

I hereby authorize direct remittance of payment for all insurance benefits to Cheryl Jansen, OD and Associates for all covered medical services and supplies provided to me during all courses of treatment and care.

I understand that insurance billing is a service provided as a courtesy, and that I am at all times financially responsible for any charges not covered by my health care benefits. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. A quote of benefits by the insurer is not a guarantee of payment. We will file your insurance claim, but not all insurance plans cover all services. In the event your insurance carrier determines a service "not covered" or "applied to deductible", you are responsible for payment.

Patient/Guardian Initials________________

Financial Responsibility:

I understand and acknowledge that I am accepting full financial responsibility for all payment for medical or vision services and/or supplies. ***Any unpaid balance over 120 days will be sent to a collections agency and a 25% collection fee will be added to the balance due.***

Patient/Guardian Initials________________

Acknowledgement of Privacy Practices:

I have been provided with a copy of the Notices of Privacy Practices for Cheryl Jansen, OD and Associates effective date of July 1, 2013.

I understand my medical records are confidential and that by signing this consent form I am allowing my medical information to be released upon my insurance provider's request for the purpose of Health Care Operations. I also understand that I may request to restrict disclosure of specific information in my medical records. Phone messages and email may be used to contact me. I can request disclosure restriction or opt out of these contact methods at any time with written request[1] to the Privacy Officer.

Patient/Guardian Initials________________

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient/Guardian
Signature____

Date

Revised 5/6/2014