ARLOW OPHTHALMOLOGY
PO Box 88, Windber, PA 15963-9118
Phone: (814) 270-6045

Patient Name: _____

Patient Financial and Payment Policy

I attest that I have provided current and correct insurance card and billing information. My insurance policy is a contract between myself and my insurance company. It is my responsibility to know my insurance benefits. Arlow Ophthalmology will bill my insurance, but I understand this does not guarantee coverage. I understand I will be billed for any remaining portion due after my insurance processes my claim.

I understand co-pays are due at the time of service.
I understand a $20.00 returned check fee will be charged for checks with insufficient funds.
Workers' Compensation Plans: I understand I am responsible for ensuring that my employer submits the correct documentation for the claim. If this claim is denied then I understand the bill will become my responsibility.

I understand that I am financially responsible for all charges regardless of third-party involvement. I agree to pay any deductible, co-insurance; copay or any service(s) deemed a "noncovered benefit" by my insurance company. I understand that failure to pay outstanding balances within 90 days of receiving my first statement will result in submission of my account to an outside collection agency. If the debt remains after transfer to an outside collection agency, the debt may be reported to credit bureaus and my credit rating may be affected. In addition, failure to pay delinquent account balances may result in my termination of care from Arlow Ophthalmology.

No Show Policy

I attest that I will contact Arlow Ophthalmology as soon as possible if my schedule changes and I cannot keep my appointment. As a courtesy, I will provide at least 24 hours notice.

"No Show" shall mean any patient who fails to arrive for a scheduled appointment. "Same Day Cancellation" shall mean any patient who cancels an appointment less than 24 hours before their scheduled appointment. "Late Arrival" shall mean any patient who arrives at the clinic 30 minutes after the expected arrival time for the scheduled appointment.

If I No Show, Cancel Same Day or am a Late Arrival, then I may be assessed a $20.00 "no-show" service charge to my account. This "no-show charge" is not reimbursable by my insurance company. I will be billed directly for it either on my card or before my next appointment. Arlow Ophthalmology reserves the right to dismiss me from their practice after three consecutive infractions of this policy.

Consent to Treat Form

1. I give permission to **Arlow Ophthalmology** to provide me (or grantor) medical treatment.

2. I allow **Arlow Ophthalmology** to file for insurance benefits to pay for the care I receive.

   I understand that:

   - **Arlow Ophthalmology** will send my medical record information to my insurance company.
   - I must pay my remainder of the costs.
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.
   - I have been provided access to and options to acquire the HIPAA Notice of Privacy Practices for **Arlow Ophthalmology.**

3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician.
   - I agree to the Financial and No Show Policies.

_____ _____

Patient's Signature Date

_____ _____

Parent/Guardian/POA Signature (patient <18years old) Date

_____

Print Signer's Name