OMAHA CENTER FOR SIGHT
THE CLEAR CHOICE.

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Office Policies and Privacy Notice

Thank you for choosing Omaha Center for Sight (OCS) for your eye care needs. All patients must agree to our financial and privacy policies before receiving treatment. If you are a Medicare participant, a signature is required stating that you agree with the financial terms of Medicare.

Please ***read and initial*** each section below indicating your acceptance of them and sign at the end. A copy of this financial policy and/or the privacy policy will be provided to you upon your request.

____ INSURANCE POLICY: I understand that OCS files medical insurance claims for patients as a courtesy, that I am financially responsible, and I agree to pay all the fees that are not otherwise paid by or billed to my insurance or any other payer. ***It is my responsibility to confirm benefits and coverage prior to services provided.*** I understand that OCS does not file third-party claims but will provide any information that is required.

____ PAYMENT POLICY: I understand that co-payments are due at the time of service and that if my deductible is unmet a ***down payment of $200*** will be collected at the time of services. Any unpaid balances or non-covered services will be billed to me and are due within 30 days of the statement date unless other arrangements have been made with OSC. Payments may be made by cash, check, or credit card. I understand that the charge for a returned check is $25.00.

____ REFRACTION: I understand that a refraction is a test which is used to determine my eyeglasses prescription. It is not covered by most insurance companies, including Medicare. I understand that **I will be charged $60** for a refraction which is due at the time of service.

____ NO-SHOWS & LATE CANCELLATIONS OR RESCHEDULES: I understand that if I do not show for my appointment or fail to cancel or reschedule my appointment within 24 hours of my scheduled date and time, **I will be charged a fee of $50**. If I fail to show for my scheduled surgery or fail to cancel or reschedule my surgery within five (5) days of my scheduled surgery date, I will be charged a fee of $250.00. (OCS reserves the right to dismiss patients who habitually miss appointments.)

____ WORKERS' COMPENSATION CASES: I understand that charges for services rendered because of a verified work-related injury will be billed to the workers' compensation carrier as a courtesy if I supply the necessary information to bill the carrier. If my workers' compensation claim is denied, or if I do not provide the necessary information, I will allow OSC to bill my medical insurance carrier, and I will be responsible for any non-covered charges.

____ MINOR PATIENTS: I understand that if the patient is a minor (18 years of age or younger), the parent or guardian is responsible for any payment due at the time of service. As the parent or guardian, I will provide the necessary authorization to treat and provide insurance card(s) for the minor patient.

____ SELF PAY PATIENTS: I understand that if I do not have medical insurance, I will be required to **pay in full the day of service**, unless other arrangements with OCS have been made.

____ ADDITIONAL CHARGES: I understand that I may be responsible for payment of additional charges including, but not limited to, contact lens fitting fees, contact lenses, completion of Family Medical Leave Act paperwork, DMV forms.

____ OUTSTANDING BALANCES: I understand that if my account becomes delinquent my account will be forwarded to an outside collection agency. I understand that all outstanding patient balances will be collected prior to each visit. (OCS has the right to refuse to see you if the previous balance is not paid in full at the next date of service.)

____ ADDITIONAL ACKNOWLEDGEMENT: I understand that no photo, video or audio recording is permitted within the OSC office.

By signing below, I understand and agree to the terms and conditions of this document.

_____ _____
Signature of patient or responsible party Date

_____ _____
Printed name of patient or responsible party Date of Birth

Account #: _____