PACIFIC VISION MEDICAL CENTER (PVMC)
Consent for Treatment and Financial Policy

PVMC is committed to providing you with the best possible health care. Accurate information and your clear understanding of our financial policy is important to our professional relationship. We ask that you complete our patient information forms annually and inform us of any interim changes. Please ask for an explanation if any of this is unclear.

Co-payments, co-insurance, deductibles, and non-covered services that have not been satisfied, are the responsibility of the patient and payment is expected at the time services are rendered.
We currently participate with Medicare, Partnership HealthPlan via referral, VSP and ODS/Moda.

If you have an insurance with which we do not participate, we expect payment at the time services are rendered. As a courtesy to our patients, we will bill up to two insurance plans on your behalf and assist you in obtaining proper reimbursement from your insurance company. However, it is **your** responsibility to know the requirements of your insurance.

PROOF OF INSURANCE: You must provide a copy of your current insurance card or pay when seen. Photo identification is required to prevent fraudulent use of insurance information.

STATEMENTS: Payment may be made by check, cash, money order, Discover, Visa, MasterCard or CareCredit. If a check is returned to us due to insufficient funds, our returned check fee is $25 and you will be required to pay for future services via cash or money order. If you receive a statement from us, our terms are 30 days. We will add a $10 late fee for any unpaid balances after that.

MEDICAL INSURANCE: All diagnostic tests and pictures of the eyes performed in our office, as well as medical eye exams, are billable to your medical insurance **only**. You are responsible for any discrepancies between our fees and the amount your carrier pays for services rendered in our office.

VISION INSURANCE: Routine eye exams and refractions (the portion of the exam which determines your best corrected visual acuity with lenses) are **not** covered by Medicare and most insurance carriers. These vision services are covered under vision insurance plans, not medical insurance plans. Except for patients who have VSP, **the charge for refraction is payable at the time of service and is separate from your exam charge. If you do not want a refraction done, please notify the doctor's assistant immediately prior to your exam.**

OPTICAL: (Glasses and Contact Lenses): Glasses are custom ordered and made. Therefore, **glasses are payable at the time of order.** Our optical department can provide you with an itemization you may use to submit to your vision plan. All contact lens orders are payable at the time the order is placed.

CAUSE FOR TERMINATION: We rarely terminate patients from our care, but we may if we decide for any reason that your continued care here is detrimental to you, to our other patients, or to PVMC. Non-compliance, repeated failure to keep appointments, offensive or abusive behaviors or other such actions may result in termination.

DILATION: Expect your eyes to be dilated. You may be blurred and sensitive to sunlight. The dilation usually lasts 4 to 6 hours but can last longer for some. Each individual is affected differently. If you've felt uncomfortable after prior dilation or have never been dilated, we recommend you make arrangements to have a driver after your appointment. We have disposable sunglasses to minimize these symptoms.

Please complete back . . .

EMERGENCIES: We are available to our patients 24/7. If you have an ocular emergency call (707) 465-2020 and follow the instructions.

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS: I authorize the release of any information requested by insurance companies or liable third parties and I assign any insurance benefits to PVMC. If insurance does not pay for any reason other than an error by PVMC, I understand that I will be responsible for the bill.

I hereby certify that I have read and understand the foregoing consent and financial policy and accept its terms. I consent to treatment by all the providers of PVMC, unless I expressly state my desire to the contrary. I guarantee payment of all charges incurred for the account of the patient listed below. **If it becomes necessary to employ an attorney or agent to enforce this document, or collect any judgment based on this document, I promise to pay all court costs and fees, whether taxable or not, in all courts, including bankruptcy and appellate courts.**

I further acknowledge that I am aware that my eyes may be dilated and have been advised that a driver may be necessary afterwards. I assume full responsibility (financially and otherwise) should I choose to drive with my eyes dilated and agree that my doctor, PVMC and its employees are released from all liability resulting from my decision.

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Patient Name

______________________________ Print Name: ____________________ __________

Signature of Patient or ☐ Legal Representative Date

Revised 7/25/2017