INLAND EYE SPECIALISTS
A MEDICAL CORPORATION

Financial Policy

As stated in the Consumer Protection Act, Inland Eye Specialists would like to inform you of our policies concerning the financial responsibilities you incur as a result of the treatment we provide you and your family.

1. You will be billed for any unpaid office visits and procedures. As a part of our service, we will submit insurance claims on your behalf, once you have provided the necessary information.

   Please Note:

   - Since your insurance is normally a contract between the insurance company and you or your policy holder, we are not part of that agreement. We will bill your insurance company as a courtesy. If it is determined that you are ineligible for benefits under your health plan or you receive non-covered and/or non authorized services, you will be responsible for payment. In some cases, we may have a specific contract with your PPO or HMO. You will be notified of those specific carriers. We will not change diagnoses to accommodate requests from your insurance carrier.
   - Our fees are usually covered up to the maximum paid by your insurance. Some insurers pay claims as a percentage, i.e., 50%, 80%, etc., of what they regard as the "Usual and Customary" charge for their plans. Our charges are considered appropriate for ophthalmology, optometry, medical eyewear and medical services in this area.

2. Please provide us with at least 24 hours notice if you are unable to keep your scheduled appointment to avoid a $35 no-show fee.
3. There will be a $35 charge on all returned checks.

TEST FOR EYEGLASSES/ REFRACTION

A test for eyeglasses is often performed during a yearly eye examination. If you have a vision plan with whom we are contracted and you are eligible for services under that plan, we will bill that plan for this examination.

If you have a test for eyeglasses (refraction) today, and you DO NOT have a vision plan, you will be charged a reduced fee of $65.00. MEDICARE AND/OR YOUR MEDICAL INSURANCE WILL NOT COVER PAYMENT FOR THIS EXAMINATION. If you DO NOT want a test for eyeglasses performed today, please inform our staff BEFORE you see the doctor.

_ _ _ _ _ _ _ _ _
Initial

CONTACT LENS EXAMINATIONS

If you are interested in receiving contact lens services, please read and initial below. If you have any questions, our opticians can explain related fees and any insurance benefits you may have.

An examination for contact lenses is done at the request of the patient (often during a yearly eye examination). This test, which includes the initial evaluation, lens fitting, any

necessary training, and follow up visits for up to three months, is SEPARATE FROM A ROUTINE EXAMINATION AND HAS A SEPARATE FEE.

The amount of the fee is based upon the complexity of your case. For most patients, fees range between $93 and $189. Charges for custom or medically necessary contact lenses are higher and will be determined on a case by case basis. If you are unsure of what your financial responsibilities will be, please ask our staff or doctor BEFORE the contact lens examination is performed. I understand the above statement and agree to responsible for payment of this fee and any other non-covered services.

_____
Initial

FINANCIAL POLICY (CONTINUED)

RELEASES

I understand and agree that I am responsible for all non- covered, non-authorized, and/or non-eligible charges pertaining to my medical care regardless of my insurance status. I have read the Financial Policy above and completed the patient information form. This information is true and correct to the best of my knowledge. I will notify you of any changes. I hereby authorize Inland Eye Specialists to release any information requested by my insurance company, admitting hospital and/or referring physicians on my behalf or minor/dependent. I hereby assign payments received for medical services rendered to me and my family to Inland Eye Specialists. I hereby authorize Inland Eye Specialists to make complaints to the State Insurance Commissioner, the Health Care Financing Administration, or the Department of Labor on my behalf regarding my benefits claims.

Signed: _____ Date: _____

(To be signed by patient or adult responsible for payment if patient is less than 18 years old)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Hemet	Murrieta	Temecula	Fallbrook	Laser Center
3953 W. Stetson Ave Hemet, CA 92545 (951) 652-4343	25395 Hancock Ave. Suite 100 Murrieta, CA 92562 (951) 696-5388	31950 Temecula Parkway Suite B7 Temecula, CA 92592 (951) 303-0575	521 E Elder Street Suite 102 Fallbrook, CA 92028 (760) 728-5728	25460 Medical Center Dr. Suite 103 Murrieta, CA 92562 (951) 698-4575
David S McCleary, O.D., Privacy Officer Mark Nilsen, Security Officer	John J McDiarmid, O.D., Privacy Officer Mark Nilsen, Security Officer	Brett R. Larson, O.D. FAAO, Privacy Officer Mark Nilsen, Security Officer	J Grant Tew, M.D., Privacy Officer Mark Nilsen, Security Officer	Jonathan M Geller, O.D., Privacy Officer Mark Nilsen, Security Officer

I hereby acknowledge that a copy of Inland Eye Specialists' Notice of Privacy Practices will be posted in the reception area and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment. A copy of our most current Notice of Privacy Practices can be viewed on our website at www.inlandeyespecialists.com

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by patient, please indicate relationship below.

_☑_ Parent or guardian of minor patient
_☐_ Guardian or conservator of an incompetent patient
_☐_ Beneficiary or personal representative of deceased patient

Name of Patient: _____

I AUTHORIZE THAT THE ABOVE INFORMATION BE RELEASED TO THE FOLLOWING:

Please check all that apply:☐Family Member(s)☐Insurance Company☐Doctor(s) ☐ Lawyer(s)☐Other
In the space provided, please list the name(s) and relationship of the person(s) authorized to receive this information.

1. Name_____
Relationship_____

2. Name_____
Relationship_____

3. Name_____
Relationship_____

Thank You!