PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Thank you for choosing Shoreline Vision as your healthcare provider. The medical services you receive imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. To assist you in understanding that financial responsibility, we ask that you read and sign this form. By signing and/or receiving services from Shoreline Vision, you agree:

Assignment of Insurance Benefits

I authorize payment of medical benefits to Shoreline Ophthalmology, P.C. for all services rendered during my visit. I understand that I am financially responsible for all charges whether or not these are paid for by my insurance.

1. You acknowledge and agree to the FINANCIAL POLICIES of Shoreline Vision. You may view the current version online at www.shorelinevision.com or request a copy from the office staff. These policies may be changed from time to time by Shoreline Vision without notice. If there is any conflict between the FINANCIAL POLICIES and this PATIENT RESPONSIBILITY STATEMENT, the FINANCIAL POLICIES will rule.

2. You are ultimately responsible for all payment obligations arising out of your services and guarantee payment for these services. You are responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility as indicated by your insurance carrier or our FINANCIAL POLICIES, which are not otherwise covered by supplemental insurance.

3. You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: (i) your health plan requires prior authorization or referral by your Primary Care Physician (PCP) before receiving services at Shoreline Vision, and you have not obtained such an authorization or referral; (ii) you receive services in excess of such authorization or referral; (iii) your health plan determines that the services you received at Shoreline Vision are not medically necessary and/or not covered by your insurance plan; or (iv) your health plan coverage has lapsed or expired at the time you receive services at Shoreline Vision. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly.

4. You will be required to follow all registration procedures, which may include updating or verifying personal information, presenting valid and current insurance cards and paying any co-pays or other patient responsibility amount at each visit. Your card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file, or are unable to verify your eligibility for benefits, you will be treated as a self-pay patient. As a self-pay patient, our fee is expected to be paid in full at the time of service. IF the insurance card or other necessary information is furnished after the visit, we may file a claim with your insurance; and, if paid in full by your insurance, you will be reimbursed. Shoreline Vision is not

responsible for any incorrect information given by you or your insurance carrier regarding your insurance benefits or benefit plans.

5. Once your insurance carrier processes your claim, we will bill you for any remaining patient responsibility deemed by your insurance carrier. If any payment is made directly to you for services billed by Shoreline Vision, you agree to promptly submit same to Shoreline Vision until your account is paid in full. If you make a payment that results in a surplus on your account, you will be reimbursed.

6. You will be mailed a billing statement that contains the total cost of your service(s) received from Shoreline Vision. Payment is due upon receipt. We accept payment by check, cash, money order, debit cards, credit cards (Visa, Mastercard, Discover, American Express) and Care Credit.

a. Payment by Check. If payment is made by check and it is returned or declined for any reason, your account will be charged a surcharge of $25.00.

b. Payment by credit card. Any debit/credit payment that is requested to be processed over the telephone will be a minimum amount of $5.00

7. **Refraction**. The physician may perform a "refraction" as part of your eye exam. The refraction allows the physician to properly evaluate your visual acuity, and to determine the overall health of the eyes. Your insurance may not consider the refraction as a covered benefit but some secondary vision plans may pay this charge. If the physician performs the refraction as part of the exam, you understand that you will be expected to pay this charge at the time of your appointment if it is not a covered benefit.

8. **Managed Care** (HMO, PPO, etc.) All managed care co-payment amounts are due at the time of service. If your insurance plan requires a referral authorization from a Primary Care Provider (PCP), you are responsible for presenting this at your initial visit. If you request an office visit without a referral authorization, your insurance plan may deem this as "out of network" or "non-covered" treatment, and you will be responsible for a larger amount or all of the charges. You acknowledge that it is your responsibility to be aware of what service are covered and you agree to pay for any service deemed to be non-covered or not authorized by the plan.

9. **Medicare**. Shoreline Vision is a participating provider with the Medicare program and accepts as payment the Medicare allowable, patient deductible and/or 20% co-insurance. Medicare or secondary carriers do not cover some services. Please make certain that you understand which aspects of your service are covered before proceeding. You understand that you will be responsible for your annual deductible, the co-insurance, and any non-covered services specified by Medicare. We will submit a claim to any supplemental plan you have, so long as you provide all necessary policy information.

10. **Medicaid**. If you are a Medicaid subscriber, you must present a valid eligibility card at the time of registration and prior to the time of service. Your eligibility status will be verified. Your service(s) will be billed to Medicaid. You are responsible for non-covered services and spend-down requirements associated with your individual coverage.

11. **Workers Compensation Cases**. Charges for services incurred as a result of a work-related injury will be treated as workers' compensation. You must provide necessary information to bill the carrier or your employer. You are responsible for the completion of information with the employer and approval of the workers' compensation claim. If your workers' compensation claim is denied, we will bill your regular medical insurance carrier.

12. **Non-payment of services**. Any unpaid service(s) that is the responsibility of the patient shall be subject to the following systematic procedure for collection of a debt. Patients will not receive a billing statement until there is patient responsibility of greater than $5.00. After the initial billing statement (referred to as statement 1), another billing statement shall be sent 30 days later (referred to as statement 2). A final and third billing statement will be sent after another 30 days. Patients with balances that remain unpaid after 105 days will receive one final "demand letter". The demand letter will afford the patient an additional 15 days to submit payment in full. If no payment is received Shoreline Vision will turn over the unpaid balance to a collection agency. Shoreline Vision has the right to disclose to the collection agency all relevant personal and account information necessary to collect payment for service(s) rendered. If your account is referred to a collection agency, it may have an adverse effect on your credit history.

13. **Payment arrangements**. Payment is due upon receipt of the initial billing statement. However, Shoreline Vision recognizes that certain circumstances may require a patient to request time to pay a balance due. Shoreline Vision's policy regarding payment arrangements is as follows: (i) any unpaid balance less than $100.00 will have a minimum monthly payment requirement of $10.00; (ii) any unpaid balance greater than $100.00 but less than $500.00 will have a minimum monthly payment requirement of $25.00; (iii) any unpaid balance greater than $500.00 will have a minimum monthly payment requirement of $100.00; (iv) any credit card payment to be processed over the telephone will be required to be a minimum of $5.00. A patient will be requested to sign the proposed payment agreement. Patient's may come to the office or choose to have an agreement mailed to them. Failure to return the proposed agreement with a signature will cause the agreement to become void.

14. **Minor Patients**. The parent/guardian of a minor is responsible for payment of the minor's account balance. Upon registration, the parent/guardian that accompanies the minor and provides all necessary information will be entered as the responsible party for payment.

15. **Release of Information**. I authorize Shoreline Ophthalmology, P.C. to release all information necessary to secure payment from my insurance company on my behalf. I authorize Shoreline Ophthalmology, P.C. to release my medical records to: 1) any third party responsible for paying for my care; 2) any outside peer review or an auditing agency engaged by a third party payer to review my medical records; 3) Any third party health care service provider responsible for my personal care including but not limited to hospitals and consulting physicians; 4) any other person I designate in writing as my agent and/or patient advocate to act for me as permitted by State and Federal law.

ACKNOWLEDGEMENT

By signing below, the undersigned acknowledges that: (i) I have been provided a copy of the Shoreline Vision PATIENT FINANCIAL RESPONSIBILITY STATEMENT; (ii) I have read, understand and agree to their provisions and agree to the specified terms; (iii) I agree to pay all charges due (or become due) to Shoreline Vision including co-payments, co-insurance and deductibles as required or provided pursuant to my insurance plan(s), (iv) benefits, if any, paid by a third-party will be credited on the patient's account, (v) regardless of my insurance status or absence of insurance coverage, I am ultimately responsible for the balance on the account for any service(s) rendered, (vi) failure to pay may result in my account being turned over to a collection agency and can adversely affect my credit report.

I further agree that a photocopy of this Patient Responsibility Financial Statement shall be as valid as the original.

ONCE I HAVE SIGNED THIS AGREEMENT, WHETHER BY ORIGINAL, FASCIMILIE OR ELECTRONIC SIGNATURE, I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.

______________________________________ ____________________

Patient/Responsible Party/Guardian Date

____

Witness