

S.E. Professionals, SC, dba

Premier Vision

Fox Point Fredonia Mequon

Insurance Notice

Please remember that health and vision insurance is considered a method of reimbursing the patient for a contractually agreed upon portion of the fees charged for services rendered. This contract is between you and your insurance provider. It rarely provides full reimbursement and is not a substitute for your responsibility for payment. Unless we have contractually agreed to accept the assigned allowance, it is your responsibility to pay any charges not paid by your insurance. It is always your responsibility to pay deductibles, co-insurance, and any other "out of pocket" expense as defined in your insurance plan.

There are thousands of insurance plans available today. Our staff will make the best effort to help you determine your benefit levels and inform you of your out of pocket expense for your procedures. However, on occasion, we will receive incorrect information from an insurance carrier, leading to differences in your out of pocket expense from what they tell us to what they ultimately pay. Every time you or we contact an insurance provider, a disclaimer that a phone call is not a guarantee of benefits is a part of that call. We cannot be responsible for insurance company errors. It is always your responsibility to pay all patient responsibility amounts.

Financial Assignment

I request that payment of authorized insurance benefits and/or Medicare benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. **I understand that I am financially responsible for all charges whether or not paid by said insurance.** I hereby authorize S.E. Professionals, SC to release all information necessary to secure the payment. I agree to remit any collection or legal fees in the event of a defaulted account.

Patient signature (parent if minor)

Date

Patient Responsibility

Because we offer comprehensive eye care, some of the care we provide may be covered under your vision insurance while other care would not be covered under vision insurance because it is considered medical care. Care provided to you for medical conditions may be covered by your medical insurance. Please feel free to discuss this with your doctor prior to proceeding with any medical care to assure that you understand your patient responsibility for the care.

Patient signature (parent if minor)

Date

Acknowledgement of Receipt of Privacy Practices

I acknowledge that I have the option to request a copy of S.E. Professionals' Privacy Practice notice which describes in detail how S.E. Professionals may use and disclose my private health information.

Patient signature (parent if minor)

Date

Red Flag:	<input type="checkbox"/> Asked Patient for photo ID	Date: _____
<input type="checkbox"/>	Copy in Chart	<input type="checkbox"/> Patient declines copy in chart
<input type="checkbox"/>	Does not have a photo ID	
<input type="checkbox"/>	Declines to provide photo ID	