**Mary Washington Eye Care Center Financial Policy**

We ask that all patients pay for their office visits and applicable co-pays at the time of service, unless you have a previously arranged payment plan agreement. Our mission is to improve the health status of all people in our community. One way we do this is by offering charity care (this is also called free care) discounts on medical bills and payment arrangements for medical bills. This help is only for "medically necessary" services. If you believe you qualify for financial assistance, please ask for additional information.

**Returned Check Fee:** I understand and agree that if any payment made by me or on my behalf by check is returned from the financial institution as unpaid, I am responsible and agree to pay a $25 returned check service, in addition to the original amount.

**No Call, No Show Policy:** Failure to cancel within 24 hours of your appointment may result in a $40 charge.

**Your Eye Examination:** Eye Examinations can have two portions, the **eye exam** and the **refraction**. The **refraction** is the measurement taken to determine if there is a need for glasses and if needed will result in a glasses prescription. Refractions may be done for routine eye exams or medical exams.

You **will be refracted** for the following reasons:

- Your vision has dropped by more than 2 lines on the eye chart
- You have any visual discomfort
- It has been more than 2 years since your last refraction

Most medical insurance plans, including Medicare, do not pay for refractions. You may be asked to pay the refractive exam fee at the time of your visit. ***Routine vision insurances cover this service as part of a comprehensive eye exam.***

**Contact Lens Services:** If you currently wear or wish to begin wearing contacts, there is a separate charge for the contact lens services. If this fee is not covered by your insurance, payment will be due at the time of service. *Your contact lens exam fee covers 3 months of contact lens follow up care. If your contact lens prescription is not finalized within that time, you may be subject to additional fees.*

**Use and Disclosure of Protected Health Information:** I understand that Mary Washington Healthcare and its related Affiliates (the "Facilities") may use and disclose my protected health information for purposes of treatment, payment and health care operations. I also acknowledge that I have received, have been offered, or have received in the past a copy of the *Notice of Privacy Practices* for the Facilities, which provides information about how the Facilities, and individuals involved in my care at the Facilities, may use and disclose my protected health information. As provided in the *Notice,* the terms of the *Notice* may change. To obtain a copy of any current *Notice*, please contact the Privacy Officer at 1.800.442.8762. I understand that I have the right to request that the Facilities restrict how my protected information is used or disclosed for treatment, payment of health or health care operations, but I also understand that the Facilities are not required to agree to a requested restriction. However, if the Facilities do agree, they are bound by that agreement.

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Signature of patient or responsible party Date

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Print Name Relationship to patient