GARLAND VISION SOURCE™

BRETT HAGEN, O.D.
JEZZARAE HEDLUND, O.D.

FINANCIAL POLICY

Payment in full, for all products and services, is expected at the time of service; except for those covered by your insurance policy.

INSURANCE BILLING POLICY

As a courtesy to our patients, Garland Vision Source, Inc., agrees to submit a claim, on behalf of the patient, to insurance carriers for which we are providers. Please clarify with our insurance manager if you are eligible for this service.

~ Deductibles and co-payment are due at the time of service.

If your insurance is through a managed health care program, we are obligated to follow your service contract regarding referrals to other specialists, even when that means a delay in your care.

Due to insurance limitations, it may not be possible to obtain a referral from your primary care physician after you have already received treatment in our office. You may be responsible for the costs associated with services obtained without a referral.

~ It is your responsibility to verify authorization for care with your insurance company.

~ After payment is received from your insurance company, any remaining balance on your account past 30 days will be assessed a finance charge. I understand and agree to these terms.

INFORMED CONSENT

I authorize the doctors of Garland Vision Source, Inc., to examine my eyes and related structures and to perform indicated procedures.

I authorize the release of medical information about me to my insurance carrier(s) for the determination of benefits payable for services rendered and optical goods supplied by Garland Vision Source, Inc.

I give permission for Garland Vision Source, Inc., to leave pertinent messages on my answering machine at home and/or at my place of employment, limited to requests to return the phone call.

HIPAA CONSENT

I have been informed that I may review the Notice of Privacy Practices (for a more complete description of uses and disclosures) for Garland Vision Source before signing this consent.

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Signature of Patient: _____ Date: _____

If signed by patient representative, state relationship to patient: _____