Washington Vital Vision
10803 SE Kent-Kangley Rd. Ste. 103 Kent, WA 98030-7194
Ph: 206.800.3445 | Fax 206.485.2946
www.wavitalvision.com

Financial Policy

I acknowledge that I am responsible for payment for all medical services rendered to me and/or my dependents, regardless of the decision to reimburse or not reimburse made by my insurance carrier. I also understand that my insurance will be billed as a courtesy to me. It is my responsibility to know my coverage terms, including the need for prior authorization. I hereby assign benefits to which I am entitled for medical and/or surgical expenses relative to the services performed. I am liable for all charges for services rendered. This authorization shall continue and be in full force and effect until revoked in writing by me. If I refuse to sign below, I understand that my insurance will not be billed and I am prepared to pay, in full, all services rendered to me at the time of service.

I understand that I may be charged for the following services that my insurance may deem as non-covered benefits. I understand that fees are due at the time of services.

Refraction (test for glasses prescription): $65

Elective Contact Lens Fittings: $130

DMV Report of Vision Exam: $20

FMLA or Disability Forms: $50

Two consecutive missed appointments: $50

HIPAA Notice of Privacy Practices

I am aware of the privacy standards of Washington Vital Vision and my rights and responsibilities as a patient under the Healthcare Portability Act of 1996 (HIPAA) and other governmental regulations. All exchanges of information including prescription history, medical history, and conversations about my condition will be in accordance with Washington Vital Vision's policy. I am also aware that there are times when Washington Vital Vision will share my medical chart with other physicians who participate inmy medical care. I give permission for Washington Vital Vision to share my medical records with others in the medical field to assist in my over-all medical care.

I authorize the practice to release any or all information concerning my medical care to other physicians, insurance carriers, and other medical institutions who collectively care in my healthcare.

By signing below, I acknowledge and agree to the Financial Policy and HIPAA Notice of Privacy Practices at Washington Vital Vision.

Name: _____ Date: _____

Signature: _____