PULLMAN
VISION SOURCE®

James P. DeVleming, O.D.

Financial Policy

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Initial

Payment for all services, is expected at the time of service; except for those covered by your insurance policy. A fifty percent deposit is required on all eyewear and contact lens orders and the balance is due when eyewear and/or contact lenses are dispensed. All co-pays and contact lens fitting fees, when applicable, are due at the time of service. Any balance remaining on patient's account past 30 days will be assessed a finance charge. Delinquent accounts will be turned over to a collection agency.

Insurance Billing Policy

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Initial

As a courtesy to our patients, Pullman Vision Source agrees to submit a claim, on behalf of the patient, to insurance carriers for which we are providers. It is the undersigned's responsibility to handle any and all problems that arise with your insurance company. Pullman Vision Source cannot guarantee anything about the undersigned's insurance, as the contract is between the undersigned and their insurance company, not with this office. We will assist in providing information, but it is the responsibility of the undersigned to know their insurance and benefits.

I understand Pullman Vision Source accepts assignment for Medicare, Premera Blue Cross, Group Health, Regence and certain other HMOs and PPOs with which they are affiliated, and that I am responsible for a deductibles, co-pays and or/fees for non-covered services and contact lens fitting fees if applicable. I authorize payment of insurance benefits directly to Pullman Vision Source for professional services rendered. 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 Pullman Vision Source.

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.

If you have insurance with which we are unfamiliar, or that we know from experience will not pay benefits directly to us, the undersigned will be responsible for fees for services rendered at time of service.

Informed Consent

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Initial

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

HIPAA Consent

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Initial

I have been informed that I have been offered the Notice of Privacy Practices (for a more complete description of uses and disclosures) of Pullman 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.

Patient Name (print): _____ Signature of Patient: _____

Date: _____ if signed by a patient representative, state relationship to patient: _____