DuPage Optical

207 S. Addison Road, Addison, IL 60101
Tel: 630.279.8866 Fax: 630.279.2609

PATIENT INFORMED CONSENT OF POLICIES
PAYMENT IS DUE IN FULL AT TIME OF SERVICE

For office use only:

BENEFIT ASSIGNMENT:

You assign all medical benefits to DuPage Optical. You also authorize DuPage Optical to release all information necessary (including photocopies of medical records) to secure payment (see Notice of Privacy Practices). You agree that if insurance pays directly to you, this monetary amount is actually due DuPage Optical and is patient responsibility.

BILLING INFORMATION:

As a courtesy, DuPage Optical files claims directly to your medical insurance or vision plans in most cases. It is your responsibility to verify your benefits and provider network coverage. If you have questions about your plan benefits, please contact your medical or vision plans directly. Balances not paid by your insurance are due within 30 days of statement date. If your account remains unpaid, it will be assessed a $25.00 late fee and be placed in collections. Once it goes to collections, it will be reported to credit reporting agency. DuPage Optical reserves the right to suspend patient care if your account is not in good standing. It is your responsibility to provide DuPage Optical with correct information including insurance, pre-certifications, responsible party, date of injury, type of accident, policy and/or group numbers, etc. Should the information change, it is your responsibility to update it within a timely manner. If you supply DuPage Optical with incorrect information, the balance of the account at the last date of service will be entirely patient responsibility. DuPage Optical will not be responsible for rebilling, appealing or other dealings with newly provided insurance company.

This policy is subject to change without notice.

METHODS OF PAYMENT:

DuPage Optical accepts credit cards, debit cards, Care Credit and personal checks as methods of payment. There is a fee of $30.00 for any checks returned by your bank. Checks shall be written to DuPage Optical.

REFUND POLICY:

Eyewear refunds – There will be a restocking fee of 25% of the total cost of the eyewear if returned within 30 days, 50% within 90 days. No refunds after 90 days.
Doctor Changes – Lenses will be remade up to 90 days from the date of the original receipt at no cost and at 50% of the original cost of lenses thereafter.
Contact Lens – Custom made lenses will have restocking fee of 25%.
Boxed Lenses – full refund if unopened and unexpired.

MISSED APPOINTMENT FEE:

A $25.00 fee will be charged for any missed appointments or appointments cancelled with less than 24 hour notice. This fee must be paid before a new appointment is scheduled or services provided. This fee is not billable or payable by insurance. Patients with more than three missed appointments will not be able to schedule appointments without a deposit of $25.00 to be applied at newly scheduled appointment. We understand that emergencies do occur and will attempt to make reasonable accommodations for that. If the appointment can be made up within the week of the missed appointment, the $25.00 fee will be waived.

WAIVER OF CONFIDENTIALITY:

You understand if this account is submitted to an attorney or collection agency or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

I have been informed of my financial responsibility and agree to the terms and conditions as stated on this form. I understand that my health insurance policy is a contractual agreement between my insurance carrier and me. It is therefore MY RESPONSIBILITY to question my insurance company regarding delays in payment and/or denial of coverage, incorrect processing of claims by the insurance company, as well as any requirements that may be included in my insurance policy coverage (i.e. Pre-certifications, in-network status, referrals, co-insurances, and deductibles).

Patient Name (print): _____

Responsible Party (print):_____

Patient (Representative) Signature: _____Date: _____/_____/____

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Authorization for Release of Information to Family Members

Patient Name_____ Date of Birth_____

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below. DuPage Optical to release my medical and/or billing information to the following individual(s):

1._____ Relation to Patient:_____

2._____ Relation to Patient:_____

3._____ Relation to Patient:_____

Patient Information I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient. You have the right to revoke this consent in writing.

Signature:_____Date:_____