FINANCIAL POLICIES
NEW ORLEANS EYE SPECIALIST

OUR PRACTICE MISSION
Drs. Leader, Balkan and Hendricks are committed to provide the most advanced, sympathetic care for your precious vision. We welcome any questions about your medical or surgical vision treatments.

OUR FINANCIAL POLICIES
While we wish that money was never a problem in medical care, it is an unfortunate reality. We feel it is better to be as clear as possible about financial matters. We want you to know about the following policies:

1. **PAYMENT** is due for your portion of any fees on the day services are rendered. We accept cash, check, Mastercard, Visa and Discover. **ANY PAYMENT ARRANGEMENTS MUST BE APPROVED IN ADVANCE.**

2. **BILLING** adds to the cost of medical treatment. Payments received within 10 days will be considered as paid at the time of your visit. After 10 days, your bill will be sent to a billing service and a $5.00 billing fee will be added to your statement at that time. A $2.50 rebilling fee will be added for each additional bill, which will be sent every 30 days for 90 days.

3. **NSF (Returned Check)** There will be a $15.00 handling charge.

4. Your insurance is a contract between you and your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are ultimately the responsibility of the patient from the date services are rendered.

5. Not all professional services, exams or tests are covered benefits in all insurance contracts. For example, a refraction (checking of glasses) is not covered by Medicare. We will only perform the services that are necessary. However, some insurance companies will arbitrarily select certain services that they will not cover. Professional services not covered but which are deemed necessary for your care will be the patient’s responsibility.

6. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance.

If you have any questions about these policies, please ask. We are here to help you.

I understand these policies.

Signature ____________________________
The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal and medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information only to those we feel are in need of your health care information.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories, insurance companies and surgical centers), for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: ________________________________
Signature: ________________________________  Date: ____________________
First Name
Last Name
Address:
City: State: Zip:
Day Phone: Home Phone:
Email: Date Of Birth:

Please let us know if you will be using any insurance. Include any questions or comments regarding your order:

How will you Receive your order?
A) Ship to new Orleans eye specialist
B) Ship to patients address

Shipping Address:
Address:
City State: Zip:

Contact Lens Prices: Show a list of lenses we supply and their prices.

Right Eye: Click to select Quantity
Left Eye: Click to select Quantity

Payment Information
Name as it appears on the card:
Credit Card Type:
Credit Card Number: Exp. Date:
Security Code:

Email for confirmation of Order and Payment Amount

Submit Your Order Clear