Stuart G. Bark, O.D.
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9815 E. Bell Road, Suite 105
Scottsdale, AZ 85260
480-419-3900

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT NAME: DOB:

Signing this document signifies that you have received a copy of our notice of privacy practices

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operation involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the Notice of Privacy Practices from Family Eyecare of Scottsdale, PLC

Patient or Legally authorized Individuals Signature Date

Print Name Relationship to Patient Witnessed by

FINANCIAL POLICY

All patient/guarantors are responsible for payment at the time of service, unless prior arrangements have been made

We accept cash, check, Mastercard, Visa, Discover and American Express

Insurance Co-payments: Insurance co-pays are paid at the time of service. We do not bill co-pays.

Deductible/Co-Insurance: Full payment will be collected at the time of service if your insurance deductible has not been met. If your deductible has been met, your co-insurance amount will be collected at the time of service.

Private Pay: If you have no insurance coverage, or insurance that we do not participate with, full payment is expected at the time of service.

Collections: Once an account is placed in "Collection Status", all future services must be paid in full at the time of service. Any balance that is assigned to a collection agency will be assessed a 40% fee to cover the collection expense.

Optional Procedures: Your doctor may recommend that you have an optional service as an important part of your eye examination. These services may not be covered by your insurance plan; full payment is expected at the time of service.

Returned checks: A $30.00 service fee will be assessed for returned checks.

I acknowledge that I am financially responsible for insurance co-pays, coinsurance and deductibles, along with all non-covered charges considered optional and/or not covered by my insurance carrier. I understand that payment is required at the time of service, unless prior arrangements have been made.

I have read and agree to abide by this Financial Policy:

Patient or Legally authorized Individuals Signature Date