DO NOT SIGN THIS COPY, eSIGNATURE WILL BE COLLECTED IN OFFICE

Patient Name: _____

Erickson's Inc p# 509-747-6148

Patient Financial Responsibility Statement / **PROOF OF DELIVERY**

421 W. Riverside Ave, Ste 770, Paulsen Bldg, Spokane, WA 99201

- **Payment due at time of service**.

As of July 1st, 2017, Erickson's Inc will no longer provide in-house financing for new charges. Payment for services rendered is due at time of service, in full, upon delivery. We accept all major credit cards (including CareCredit), cash, check, HSA and money order. Pamphlets for CareCredit are available upon request. This also hereby authorizes payment directly to Erickson's Inc by your insurance company (unless the insurance company sends it directly to you, which then you will pay Erickson's for that portion after you receive the insurance payment). If you are unable to arrange payment at time of service, you are responsible for letting Erickson's know prior to your appointment time.

- **Patient Responsibility. Total payment due at appointment:_____**

Total billed charges:_____

***Estimated "Excess Charges" Total:_____**

PLEASE NOTE: if using credit or debit, a 3% card processing fee will be added

All copays, deductibles and coinsurance are the patient's responsibility and will be withheld from any refund issued to you after Erickson's receives payment from your insurance. **Erickson's does not accept Assignment (which is also the insurance's "Allowed Amount") as payment in full, except for polishes.** You may also be billed for any balance that is unpaid by your insurance company. Some insurance plans may not show the disallowed charges, but those charges are your responsibility as per your contract with your insurance company. Insurance *Excess Charges* (all charges above the insurance's Allowed Amounts) may be patient responsibility. Please note that **any** out-of-pocket quoted to you is an estimate, and is not an exact charge. Your cost may be more or less depending on the insurance payment. If you have any questions about this, please let us know prior to your appointment.

- **ORIGINAL MEDICARE BENEFICIARIES (NOT INCLUDING MEDICARE ADVANTAGE)**

I request payment of authorized Medicare benefits directly to me or on my behalf for all services furnished to me by Erickson's Inc, except for polishes. **I understand that if Medicare assignment is not accepted, I will be receiving a reimbursement check from Medicare, in which that amount will be then due to Erickson's upon receipt, unless I have previously paid Erickson's in full at time of service.**

- **Cancellation Policy**.

__ NEW EYE/SHELL: Cancellations should be **at least 2 weeks prior**. Our business is low volume, so more than one late cancellation or no-show may result in referral to another ocularist.

__ MODIFICATION/POLISH: Cancellations should be at least 48 hours in advance.

***Should you be more than 15 minutes late for an appointment, **we reserve the right to cancel it.** Late cancellations and no-shows are subject to a fee and those fees may be non-refundable.*

- **Please provide current personal information**.

Erickson's must obtain a copy of your current valid demographics. These demographics include your current/updated health insurance which may also require prior authorization or other requirements prior to services being done. If we do not receive this information in a timely manner, your reimbursement refund may be delayed, or payment from insurance for services rendered may be denied.

- **As a courtesy, we will submit claims to your insurance.**

As a courtesy to you, Erickson's will submit your claims to your insurance company (unless otherwise requested by you) and will assist you in any way we reasonably can to help get your claims paid by your insurance company. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their requests. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.

- **Follow-up Appointments.**

Erickson's Inc allows one follow-up check-and-polish appointment free of charge after a new artificial eye/shell is made. This appointment is included in the warranty of a new prosthesis. This follow up appointment is called a "one-month check" and must be done within one month from the date of service of your new artificial eye/shell. This is to make sure we can address any concerns you may have and can modify your artificial eye/shell if needed. If you are unable to see us within one month after your new artificial eye or shell is made, you must let us know within a reasonable timeframe. Depending on the circumstances, we will arrange for you to have your "one-month check" when you are able to do so. All following appointments after your "one-month check" will be billed to you and/or your insurance at the normal cost per Erickson's fee schedule.

- **Medical Information Release.**

I authorize any holder of my medical information to be released to my insurance company and its agents any necessary information needed to determine benefits related to Erickson's services. My signature will be authorized as useful for all insurance submissions as well.

Equipment Warranty Information

Erickson's Inc will notify all patients, including Medicare beneficiaries, regarding warranty coverage of any supplies sold.

Erickson's Inc honors any custom made ocular prosthesis manufactured by Erickson's with a 90-day warranty. This warranty does NOT include surgical corrections following fabrication, normal wear and tear, or any naturally occurring changes within the eye socket causing the prosthesis to fit incorrectly. It is the patient's responsibility to advise Erickson's Inc within 90 days of the date of delivery, either by phone or in writing, of any problems that they encounter with the prosthetic eye. An appointment should be made as soon as possible to evaluate for any necessary adjustments/corrections. If any adjustments/corrections are needed, Erickson's Inc will cover all costs under the warranty and will not charge the beneficiary or the insurance company. This warranty is void if the product is lost, damaged, or if diagnostic socket conditions change in any way that is beyond the control of Erickson's Inc within the Warranty time-frame.

I understand the warranty coverage on the product I have received. I have also been given verbal and written instructions on the care and cleaning of my prosthetic eye. I am aware of how this warranty may

affect any future charges and payments for my artificial eye.

I have received, or will receive verbal and written instructions and information regarding the use and care/maintenance of my artificial eye. I have also received the Warranty information regarding the warranty of my prosthesis. The products and/or services provided to you by Erickson's Inc are subject to the supplier standards contained in the Federal regulations (Code 42 of Federal Regulations Section 424.57(c). The full text of these standards can be obtained at https://www.govinfo.gov/

Agreement to Pay if Services Denied by Insurance

I understand that if any of the services rendered or supplies delivered are not authorized prior to the date of service and I decide to keep my appointment anyway, I accept full responsibility for payment of total billed charges at the time of service. I also understand that if any of the services rendered or supplies delivered are denied by my medical insurance company *after* the insurance claim is processed, I accept responsibility for any remaining balance that is unpaid up to total billed charges.

We work hard to verify that all insurance requirements are met prior to your appointment, so maximum insurance payment can be retrieved. But please remember that insurance payment is never a guarantee - even when all insurance requirements have been met. We ask that you please call your insurance company if you have any questions regarding their payment or authorization decisions.

● Services Rendered/Products Delivered.

Prosthetic eye: V2623 (prosthesis) x1 per eye, V2628 (stents) x3 per eye

Scleral shell: V2627 (shell) x1 per eye, V2628 (stents) x3 per eye

Check and polish: V2624 (polish) x1 per eye

Modification: V2625 (enlargement) x1 per eye, V2626 (reduction) x1 per eye, V2628 x3 per eye

Clear stent only/trial shell: V2628 x2 per eye

DISCLAIMER: Although all of these terms as laid out by Erickson's may or may not pertain to me or my situation, I have read and agree that I must comply with the terms and conditions that DO apply to me as written and/or discussed prior.

Patient or Guardian/Guarantor Signature:_____

Guardian/Guarantor Name (if applicable):_____

Patient Name:_____ **Date Delivered:**_____

Personal Media Release (optional)

I agree to allow Erickson's Inc to use my photographs, videos, and/or recordings for:

☐ Education purposes

☐ Social Media

*If either option is picked, please see full terms and conditions below

Personal Media Release Terms & Conditions

I, _____, hereby authorize Erickson's Artificial
(Please print your name)
Eyes the irrevocable right and license to record my name, likeness, image, voice and performance on film, tape or otherwise, to be used in whole or in part for any and all broadcasting, audio/visual, and/or exhibition purposes in any manner or media, in perpetuity, throughout the world. These terms shall include not only Erickson's but their associates, agents, successors and licensees.

I understand that the photographs, videos, and/or recordings will be used as a record of my care, and may be used for communication with other health care professionals, educational publications, and educational lectures without notification to me. The content may also be used for advertising purposes (including website publication, facebook posts, etc) without notification to me. I further understand that if the photographs, videos, and/or recordings are used in any publication or as a part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect notification or compensation (financial or otherwise) for the use of these photographs, videos, or recordings.

I agree to indemnify and hold harmless Erickson's Inc. from and against all claims, losses, expenses and liabilities of every kind including reasonable attorney's fees arising out of the inaccuracy or breach of any provision of this Agreement. I expressly release Erickson's Inc from any and all claims whatsoever arising out of the use of my images, videos and/or voice recordings.

_____

Signature (parent/guardian/guarantor name **and** signature if/or patient is under 18 years of age)

_____

Date