Dr. Pamela S. Fraser – 877 NE 25th Ave., Hillsboro, OR 97124

FINANCIAL POLICY

Payment is expected at the time services are rendered, unless other arrangements have been made in advance. If you have insurance, as a service to you, we will make an initial attempt to bill your primary insurance carrier and see that they provide payment in a timely manner. Secondary insurance coverage is to be billed as a patient responsibility. Benefits quoted are not a guarantee of payment by the insurance, final determination can only be made when the claim is processed. If your insurance delays or disputes a claim beyond 90 days, you will need to pay your account in full and make arrangements with your insurance for reimbursement.

Our office provides standard of care as determined by the American Association of Optometry. Insurance companies may have limitations or exclusions on recommended treatments. It is up to the patient to know their insurance policy and possible limitations or exclusions. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incurred at this office regardless of insurance. Accounts 90 days old are subject to collection fees plus an $75 processing fee. There will be a service $25 charge on all returned checks. All sales are final.

SCHEDULING POLICY

Appointment times have been specifically reserved for you and we take every measure to run our schedule on time. If you will be unavoidably late for your appointment, please call us to let us know. If you arrive more than 15 minutes late, we may need to reschedule your appointment. There will be a $50 charge for "no-shows" or missing your appointment without patient cancelation.

PRIVACY POLICY and ACKNOWLEDGEMENT

A copy of our privacy policies will available by request at any time as mandated by federal law. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notices of Privacy Practices.

Patient Name: _____ Date: _____

Signature of Patient or Guardian: _____