DAVID A EWING-CHOW, MD, PLLC

2019 Financial Agreement & General Consent for Treatment

Financial Agreement

- I agree to assume full, primary responsibility for payment of all charges for services I receive from Dr. David A. Ewing-Chow, MD, PLLC that are not paid by my insurance company or other party, including items or services which are determined by the health care service plans to be covered.
- I agree that in return for the services provided to me by David A. Ewing-Chow, MD, PLLC I will pay my balance on receipt of my bill or make financial arrangements with the office for payment. Cash, check, Visa, MasterCard or Discover are accepted.
- If copayments, deductibles, and/or any non-covered service fees are designated by my insurance company, I agree to pay them to David A. Ewing-Chow, MD, PLLC at the time of service. If I fail to pay my copayment at the time of service for any reason, there will be an additional $5.00* billing service fee.
- I agree that should a balance remain unpaid on my account, it will be referred for collection with First Federal Credit Control. No further appointments will be made until your balance is paid.
- I understand and agree to pay a $35.00* service charge for any checks that are returned for insufficient funds.
- I give permission to David A. Ewing-Chow, MD, PLLC to disclose my protected health information to my insurance company or others as necessary to obtain payment for services, including confidential HIV-related information, unless I request, prior to obtaining services, that my protected health information not be disclosed to my health plan.
- If I request that my protected health information not be disclosed to my health plan, I agree to pay David A. Ewing-Chow, MD, PLLC in full for the cost of services.

Assignment of Benefits

- I assign to David A. Ewing-Chow, MD, PLLC any monies and benefits payable to me under any health insurance including Medicare, a secondary insurance or other insurance policy, governmental program, or other party providing benefit for all or a part of service provided.
- I certify that the information given regarding my insurance(s) is correct and current.

Insurance Pre-Certifications

- When authorization from my insurance company or another party is necessary for payment to be made, I agree that I am responsible to inform and obtain the authorization from my insurance company or other party before service is given. I understand that if a pre-authorization and/or referral are required and not obtained, or incorrect, the guarantor is ultimately responsible for full payment of account, including outside collection costs. We reserve the right to cancel your appointment within 3 business days of your scheduled appointment if prior authorization/referral is not obtained.

Out-Of-Network

- If I belong to a plan David A. Ewing-Chow, MD, PLLC does not have a contractual agreement with, I understand that I am obligated to pay the full charges of all services rendered to me by David A. Ewing-Chow, MD, PLLC at the time of service. A list of the insurances we participate with is available on our website, or in our office and can be provided at your request. Should you choose to still see Dr. Ewing-Chow, you will be required to complete an Out-of-Network Agreement.

Canceling/Rescheduling Appointments

- David A. Ewing-Chow, MD, PLLC requires at least 24 hours' notice to change or cancel appointments. If an appointment is missed without a prior phone call to our office, there will be a missed appointment charge of $50.00*.

Appointment Reminders and Preferred Optical Shop

- Indicate preferred appointment reminder: Phone#_____ ☐Voice ☐Text ☐ Email: _____
- Would you like Patient Portal access to your health information ☐ YES ☐ No Email: _____
- Consent to send glasses RX to Optical Shop ☐ YES ☐ NO Name of Facility: _____

***These fees are subject to change without notice.**

Consent and authorization for Treatment: I give consent for Providers and/or staff of David A. Ewing-Chow, MD, PLLC to evaluate/treat me. I understand this may include various vision tests, procedures and/or treatment as deemed necessary by Providers of David A. Ewing-Chow, MD, PLLC.

Initial _____

I certify that I have read the above and I understand its contents. I may be responsible for payment under common law or statutory law even if I do not sign this document.

_____ _____

Date **Patient Name – Please Print**

_____ _____

Relationship to Patient **Parent or Legal Guardian**