North Woods Optics

20 N Lake Street, Suite 101
Forest Lake, MN 55025
651-464-4824

Patient Financial Responsibility, Assignment of Benefits, Notice of Privacy Practices Agreement

Financial Responsibility Statement

The doctors and staff are committed to providing you with thorough, professional eye care. If you have medical insurance that covers eye care or other vision insurance, we will be glad to help obtain any forms you may need to assist you in receiving your maximum allowable benefits.

Payments for all services are due at the time the services are rendered by this office*. You are responsible for any co-payments, deductibles or fees for non-covered services. We will bill and receive payment directly from your insurance company for covered services. You will be responsible for the remaining balance. Please contact your insurance company to find out if we are in-network for your insurance plan.*

We must emphasize that as eye care professionals, our relationship is with you and not your insurance company. You are ultimately responsible for all fees for both services and materials delivered to you by this office. 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 in the management of your account.

Assignment of Benefits Authorization/Release of Medical Information

I authorize all payments from my insurance carrier be made directly to Dr. Kevin Bahr, OD, or Forest Lake Optometric DBA North Woods Optics. I certify that the information I reported with regard to my insurance coverage is correct. I further authorize the release of any information for this or any related claim to my insurance company, and will permit a copy of this form to be used in place of the original.

Notice of Privacy Practices

A copy of North Woods Optics' Notice of Privacy Practices has been made available to me. I understand the rights I have as a patient with regards to my protected health information.

I have read, understand and agree to the Financial Responsibility Statement, the Assignment of Benefits Authorization/Release of Medical Information and the Notice of Privacy Practices.

Signature _____ Date _____
(Patient or parent if patient is a minor)