TERANCE COCHRANE, OD
9730 S. MCCARRAN
SUITE 1
RENO, NV 89523
(775)787-3939

FINANCIAL AGREEMENT

ALTHOUGH MY INSURANCE MAY BE BILLED AS A COURTESY TO ME, I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW WHETHER OR NOT DR. COCHRANE IS A PARTICIPATING PROVIDER ON MY PLAN AND TO KNOW MY COVERAGE AND ELIGIBILITY STATUS. ANY INSURANCE QUOTES GIVEN OVER THE PHONE ARE ESTIMATES ONLY AND I AM RESPONSIBLE FOR ANY UNPAID BALANCE AFTER 30 DAYS. ANY CO-PAYMENTS REQUIRED MUST BE PAID AT THE TIME OF SERVICE AND IF MY INSURANCE CANNOT BE VERIFIED DURING MY APPOINTMENT TIME, I MUST PAY UP FRONT FOR ANY MATERIALS ORDERED. THERE IS A $25.00 SERVICE CHARGE FOR ALL RETURNED CHECKS.

IF NO INSURANCE IS BILLED, PROFESSIONAL FEES ARE DUE AT TIME OF SERVICE. FOR EYEGLASSES AT LEAST 50% IS DUE WHEN ORDERED WITH THE BALANCE DUE WHEN RECEIVED OR WITHIN 30 DAYS FROM THE TIME THEY WERE ORDERED (WHICHEVER COMES FIRST). CONTACT LENSES MUST BE 100% PAID FOR PRIOR TO THEM BEING ORDERED.

I UNDERSTAND THAT IF I DO NOT PAY MY ACCOUNT WITH DR. COCHRANE IN FULL, THAT MY ACCOUNT MAY BE ASSIGNED TO A COLLECTION AGENCY FOR COLLECTION.

I UNDERSTAND THAT IF MY ACCOUNT IS ASSIGNED TO A COLLECTION AGENCY, THE COLLECTION AGENCY WILL CHARGE A COMMISSION OR FEE WHICH MAY BE AS MUCH AS 50 PERCENT OF THE AMOUNT I OWE TO DR. COCHRANE. I AGREE THAT IF MY ACCOUNT IS ASSIGNED TO A COLLECTION AGENCY, THAT DR. COCHRANE MAY ADD THE AMOUNT OF THE COLLECTION AGENCY'S COMMISSION OR FEE TO THE AMOUNT THAT I OWE DR. COCHRANE, AND I AGREE TO PAY THAT ADDITIONAL AMOUNT.

I UNDERSTAND THAT THE ADDITION OF A COLLECTION AGENCY'S FEE OR COMMISSION TO MY UNPAID BALANCE MAY WELL RESULT IN MY OWING A SUM SUBSTANTIALLY IN EXCESS OF THE AMOUNT OWED FOR (MEDICAL/VISION) SERVICES. I UNDERSTAND, FOR EXAMPLE, THAT IF THE UNPAID BALANCE THAT I OWE TO DR.COCHRANE IS $100.00, THAT DR. COCHRANE MAY ADD UP TO $50.00 TO MY ACCOUNT, AND I AGREE TO PAY THE SUM OF $150.00 IN SUCH EVENT.

I UNDERSTAND AND AGREE THAT IN THE EVENT LEGAL ACTION IS COMMENCED TO ENFORCE MY OBLIGATIONS HEREUNDER, THAT I WILL PAY COURT COSTS AND REASONABLE ATTORNEY'S FEES.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

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 OPERATIONS INVOLVING OUR OFFICE. THE NOTICE OF PRIVACY PRACTICES YOU HAVE BEEN SHOWN DESCRIBES THESE USES AND DISCLOSURES IN DETAIL. WE CAN PROVIDE A FREE COPY TO TAKE.

WE ALLOW FRIENDS AND SPOUSES TO ACCOMPANY PATIENTS IN THE EXAM ROOM. BY YOUR ALLOWING THEM INTO THE ROOM, YOU ARE GIVING US PERMISSION TO DISCUSS EXAM RESULTS AND YOUR PROTECTED HEALTH INFORMATION IN THEIR PRESENCE. PLEASE INFORM THE STAFF AND DR. COCHRANE IF YOU DO NOT WISH THEM TO BE PRESENT DURING ANY PORTION OF THE EXAMINATION.

I ACKNOWLEDGE THAT I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES FROM TERANCE COCHRANE, O.D.

_____ _____

SIGNATURE DATE

IF SIGNING AS A PERSONAL REPRESENTATIVE, DESCRIBE LEGAL RELATIONSHIP TO THE PATIENT: _____

09/2015