

FINANCIAL POLICY

INSURANCE BILLING

We will gladly bill your insurance for services provided in this office; however, we do need your help. It is impossible for us to know the terms and conditions of every insurance policy.

1. Please make sure we are given a copy of your most recent insurance card. Many companies have/are changing identification numbers.
2. **KNOW YOUR COVERAGE!** You should know the amount of your co-pay, the amount of your deductible, and any limitations or exceptions set in your coverage. If you have questions about your plan, the best source for answers is the 800 number on your card. If any claim we send to your insurance company is denied, you are responsible for payment.
3. Please make all copays at time of service.

WHAT HAPPENS IF I FORGET MY INSURANCE CARD?

We will bill your insurance carrier if you can provide all of the necessary information needed for billing. If you are unable to provide your insurance card, you will be considered private pay.

WHAT HAPPENS IF I DO NOT HAVE A REFERRAL FROM MY PRIMARY CARE PHYSICIAN?

You are responsible for contacting your primary care doctor to obtain a referral. You are financially responsible for all services performed, whether or not a referral is presented.

EYE REFRACTION

Refraction is the process of determining the optimal eyeglass prescription for your eyes. This not only enables us to provide glasses but **MORE IMPORTANTLY**, to determine how well you can see. We need the information to distinguish vision problems caused by poor focus (glasses) from problems caused by eye disease.

A refraction may or may not be performed at the time of your visit, depending on our doctors' judgment of its necessity. Medicare and many insurance companies do not provide this service as a benefit. When it is performed there will be a fee of \$45 that the receptionist will request at the end of your visit.

POLICY AGREEMENT

General Medical Consent: The patient or the patient's legal representative hereby consents to general and medical care, including but not limited to x-ray examinations, laboratory procedures and medical services rendered to the patient under the general and special instructions of the physician. It is understood that the patient is under the care and supervision of his or her attending physician. **Release of Information:** to the extent necessary to determine insurance benefits, liability for payment and to obtain reimbursement, Eye care Center, may disclose portions of the patient's medical record and account file to any person or corporation which may be liable for all or any portion of the patients charges including but not limited to insurance companies, health care service plans or worker's compensation carriers. **Assignment of Insurance Benefits:** I authorize Eye Care Center, to file insurance claims on my behalf for services rendered and authorize payment directly to Eye Care Center of any benefits both basic and major medical otherwise payable to or on behalf of the patient for all services rendered.

I have read and understand the office policy on refraction, and understand that this policy will apply to all my future visits.

I have read the financial policy and I understand that I am financially responsible for all charges whether or not paid by my insurance.

Signed: _____ Date: _____