**UNIVERSITY EYE ASSOCIATES OFFICE POLICIES**

***Please carefully read and initial each important item and sign at the bottom of page.**

## Financial and Insurance Filing Policy

Payment is due at the time of service for professional services and/or orders for contacts or glasses. At your visit we will collect any copay, deductible amounts not met and any co insurance. We accept Cash, Check, Visa, Master Card, American Express, Discover and CareCredit for payment.

- All charges are your responsibility, whether or not your insurance company pays. Not all services are covered in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We cannot become involved in disputes between you and your insurer regarding covered charges, deductibles, coinsurance or copayments.
- Our practice files both routine and medical insurance claims depending on diagnosis determined by the doctor at the time of your visit.
- If your insurance company does not pay your claim within 30 days it is your responsibility to contact them to expedite payment. If your insurance company refuses to pay, you are responsible for payment. Delinquent accounts are sent to a collection agency.
- In the event that refractions are not covered by your insurance you will be charged a fee in addition to your co pay and/or deductible. (MEDICARE/ MEDICARE REPLACEMENT PLANS DO NOT COVER REFRACTIONS.)
- Canceled or rescheduled appointments are subject to a $30.00 fee if we do not receive 24 hour advance notice.
- Our office charges a $50.00 additional fee for any afterhours visit. This may or may not be covered by your insurance policy.
- Glasses are custom orders with each patient's individual specifications. Balances for glasses must be paid in full prior to order. These purchases are non-returnable and non-refundable.
  **Initials _____**

## Authorization to Release Health Information and Assign Benefits

I authorize the release of all necessary Protected Health Information and assign all medical and vision benefits to University Eye Associates. I also request that payment of authorized Medicare (if applicable) benefits be made on my behalf to University Eye Associates for any services furnished to me by University Eye Associates. I authorize any holder of medical information related to me to be released to the Centers for Medicare & Medicaid Services (CMS) & its agent, any information needed to determine these benefits or the benefits payable to related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 12 of the CMS 1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the supplier agrees to accept the charge determination the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co pay and non-covered services. Copay and deductibles are based upon the charge determination of the Medicare carrier. I understand that I am ultimately responsible for any bill incurred in this office. Should this account become delinquent, I will be responsible for any and all legal fees, court cost and collection charges. There will be a service charge for each returned check. This authorization & assignment will remain in effect until revoked by me in writing. A photocopy of this authorization & assignment is to be considered as valid as the original. I request that you file my insurance and I have agreed to & completed all of the conditions listed above. I accept financial responsibility for all charges. I have read and understand this information and I am signing voluntarily.

**Initials _____**

## HIPAA Privacy Practices

The law requires that we make every effort to inform you of your rights related to your personal health information (HIPAA**).** Your signature acknowledges that you have received and /or have been given the opportunity to review University Eye Associates Notice of HIPAA Privacy Practices for protected health information.

## Consent to Treat

I hereby authorize University Eye Associates to provide a diagnosis and treatment for myself or my child. I further authorize the release of Protected Health Information to additional physicians in order to facilitate continuity of care.

**My signature acknowledges that I have read and understand all of the above practices and policies and that I am signing voluntarily.**

_____ _____

**Patient or Legal Guardian Signature** **Date**