CENTER FOR
ADVANCED EYE CARE

FINANCIAL POLICY

Thank you for choosing Center for Advanced Eye Care for your eye care needs. We are committed to providing you with the best treatment available. The following is a statement of our Financial Policy.

All new patients must complete our patient registration forms before seeing the physician.

- *ALL CO-PAYS ARE DUE AT DATE OF SERVICE*
- *UNLESS WE ARE BILLING YOUR INSURANCE, PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE*
- *FOR YOUR CONVENIENCE WE ACCEPT CASH, CHECK, ALL MAJOR CREDIT CARDS AND CARE CREDIT*
- *RETURNED CHECKS ARE SUBJECT TO A FEE*

REGARDING INSURANCE: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will bill your insurance plan for you if you provide us with the correct information. ***Please be aware that some of the services offered may be a non-covered service or not considered medically necessary under your insurance plan.*** You, as the patient, are ultimately responsible for payment for all services provided by Center for Advanced Eye Care. While payment is your responsibility, we will assist you in negotiating a settlement with your insurance company for any disputed claim.

PATIENTS WITH BOTH MEDICAL AND VISION COVERAGE: Your vision insurance is intended to provide you with a routine eye exam. If you are being evaluated for medical reasons (corneal disorders, diabetes, cataracts, glaucoma suspect, double vision, etc.), you are being provided with medical care. Typically, your vision company does not provide coverage for medical care. Therefore, we will file a claim with your medical insurance for visits related to medical complaints and problems. Your doctor will be able to answer any questions about your treatment.

MEDICALLY NECESSARY CARE: We will only provide you with a service if we consider it medically necessary. We routinely perform diagnostic tests, which some insurance carriers will not cover. Therefore, if your insurance company arbitrarily determines that a service, we have rendered to you is not a covered benefit, you will be responsible for the bill.

Patient Initials	Date

ASSIGNMENT OF BENEFITS

I request the payment of authorized Medicare or other insurance company benefits to be made on behalf of me or my dependent(s) to Center for Advanced Eye Care for any services rendered. Regulations about Medicare assignment of benefits apply. Center for Advanced Eye Care accepts Medicare Part B assignment.

I authorize Center for Advanced Eye Care to release medical or other information about me or my dependent(s) insurance carriers for related Medicare or other insurance company claims. I permit a copy of this authorization to be used in place of the original and request medical insurance benefits from the party who accepts the assignment. I understand that it is mandatory to notify the health care provider of any other party responsible for paying for me or my dependent(s) treatment. I agree to pay all fees for such treatment. I agree that I will not withhold or delay payments if Medicare or other insurance companies deny payment on any of my or my dependent(s) charges.

Signature	Date