PEDIATRIC EYE ASSOCIATES
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OFFICE POLICY

To Our Families:

Thank you for choosing Pediatric Eye Associates for your ophthalmology care. Your assistance in complying with our office policy will help to keep patient flow as smooth as possible and your medical fees at a reasonable cost.

Co-payment is due at the time of service for all office visits. If you do not have insurance, full payment is expected. If you have an HMO referral or are a part of a PPO to which we belong, your visit may be covered under medical insurance. **Please note we do NOT bill preventative visit codes, only comprehensive eye codes, and medical evaluation and management (E/M) codes, as appropriate.** The law does not allow us to waive deductible fees under any circumstances. We can lose our privileges with insurance companies for doing this.

***If your child is fortunate enough to have a normal exam, or an exam designated as routine by the insurance company, many insurance plans will not cover the visit. You will be responsible for payment.**

***Additionally, please be aware that a "REFRACTION" is a separate part of the exam required to determine if a refractive error exists and/or prescribe glasses. It is often considered not a part of medical care and is generally denied by the insurance company even when the rest of the exam is covered. If denied, you will be responsible for this charge.**

***Please be aware, we do NOT participate in any Vision Care plans.**

****For your convenience, our office accepts cash, checks, and credit cards. There is a $20.00 fee for all returned checks.**

****It is your responsibility to determine whether or not we are contracted with your managed care plan.**

****If you are with an HMO and require a referral, please bring it with you or call ahead of your visit and confirm that it has been faxed to our office. If you do not have a referral form, you will be responsible for payment.**

****Please notify us at least 24 hours ahead of time if you need to cancel. We understand that last minute emergencies do occur; however, we reserve the right to charge $70.00 for each failed scheduled appointment. This will NOT be billed to your insurance and is your responsibility.**

****We will turn over your account to a collection agency if the balance is not paid within 90 days. Accounts sent to collections will be charged a collection service fee. This amount is 25% added to the outstanding balance. Collection accounts may be reported to the credit bureau.**

We advise you to keep a copy of this Office Policy for your records. Thank you for understanding our policy. Please let the Doctor know if you have any questions, concerns, or special needs.

PATIENT NAME: _____
(PRINT)
NAME OF PARENT/GUARDIAN *accompanying patient to the visit*:

_____
(PRINT)

I have read the office policy of the office of Pediatric Eye Associates and agree to accept it as stated. A copy of the policy has been offered to me. I give permission for Pediatric Eye Associates to communicate by mail or e-mail regarding both billing matters and appointment reminders. I authorize care of my child in my absence, by signed consent.

In addition, I hereby authorize and direct payment to Pediatric Eye Associates for the surgical and/or medical benefits otherwise payable to me under terms of my insurance.

I hereby authorize Pediatric Eye Associates to release information acquired in the course of examinations or treatments, and I hereby authorize any physician, hospital, or medical care facility to provide all information on the medical history and treatment to Pediatric Eye Associates.

By signing this document, I understand that I am responsible for payment.

_____ _____
SIGNATURE of PARENT/GUARDIAN *accompanying patient to the visit** **DATE**