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. Some plans do not cover "routine eye care" and you will be responsible for the bill. The law does not allow us to waive deductible fees under any circumstances. We can lose our privileges with insurance companies for doing this.

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 may be refused by the insurance company even when the rest of the exam is covered. You may be responsible for this charge.

Please make us aware if you have a VISION CARE PLAN. We DO NOT submit to vision care plans. If you have a vision care plan payment will be due at the time of service. We will provide you with a copy of the paid superbill for you to submit to your plan. Please advise us to bill your visit as a routine eye exam and not submit to your medical insurance.

**Please notify your doctor if the visit will be submitted as routine.

**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. Please call your insurance company before your appointment if you are unsure.

**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 we will need you to sign a form indicating you will be responsible for payment if a referral is not granted.

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 reserved the right to charge $70.00 for each failed scheduled appointment. This will **NOT be billed to your insurance, but is your responsibility.

**Please direct all questions and concerns regarding billing and insurance initially to our billing company.

Thank you for understanding our policy. Please let the Doctor know if you have any questions, concerns, or special needs.

PATIENT NAME: _____

GUARDIAN NAME: _____

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 mail my child a recall card for follow-up appointments. I authorize care of my child in my absence.

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 my information acquired in the course of examination or treatment, 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.

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SIGNATURE **DATE**