AUSTIN EYE CLINIC PAYMENT POLICY (11/19/2008)

Austin Eye Clinic has a responsibility to provide quality healthcare services to patients. In the interest of maintaining a good doctor-patient relationship, we ask that you take responsibility for your financial obligation to our practice. The following are general policies we have established for our patients.

1. Insurance – Austin Eye Clinic will file claims of all applicable visits and procedures. You are responsible for payment of all deductibles, co-insurance and all non-covered services. Please remember that insurance coverage is a contract between the patient and the insurance company. The ultimate responsibility for payment rests with you.

2. Referrals and Pre-authorizations – You are required to 1) know whether or not your insurance requires a referral for medical and/or surgical treatment and 2) obtain that referral before you are scheduled to see our physicians. Our office will assist you in determining whether our doctors are participating or non-participating providers. However, this is not a guarantee of coverage. Referrals typically have an expiration date and a limited number of visits; it is your responsibility to monitor your referral status. Our office will not see a patient who does not have a valid referral.

3. No Insurance – Patients who do not have insurance are expected to pay in full for services rendered. Payment-in-full is due the day services are rendered. We accept payment with cash, check or credit card (Visa or MasterCard). We understand that individual situations may make it difficult to meet these financial expectations and we are happy to discuss other payment arrangements as needed**.** You must make these arrangements before services are rendered.

4. Returned Checks – Your account will be charged $50 for each returned check. You will be asked to provide payment by cash or credit card for the total cost of the returned check and fee.

5. Past Due Accounts – Patients who have not made an effort to make payment arrangements or have not met their financial obligation will be turned-over to a collection agency. Once an account has been sent to collections, the patient must contact the collection agency for all correspondence regarding the balance.

6. Non-Covered Services – Austin Eye Clinic will make a concerted effort to inform you if we believe a service may not be covered by your insurance company. In our professional judgment, these services are needed to render high quality medical care even though they may not be covered by insurance. You will be expected to pay for such services, even if your insurance company denies payment.

I have read the above policy. I understand my responsibilities for payment of services rendered and will fulfill my financial obligations for services rendered at Austin Eye Clinic.

______________________________ ___________

Patient Signature **Date**

Direct Assignment of Benefits and Insurance Information

Patient Name: ____

Name and Date of Birth of Policy Holder: ______________________________________

Employer of Policy Holder: ____

Name of Primary Insurance: ____

Name of Secondary Insurance: ____

I hereby instruct and direct ______________________ insurance company to pay by check made out and mailed to Austin Eye Clinic. If my current policy prohibits direct payment, it shall be made out to me and mailed to Austin Eye Clinic. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of medical or other information necessary to process my claim. I authorize Austin Eye Clinic to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

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Patient Signature **Date**

REFRACTION POLICY

The doctor performs a refraction to determine your glasses prescription. The refraction is also necessary in order to rule out certain eye problems. The refraction test occurs when your doctor shows you a variety of corrective lenses and asks you to say which lens makes the images being viewed better or worse. A refraction is an essential part of a complete and comprehensive eye examination, but is **NOT** a covered service by most medical insurance plans regardless of why the doctor performs the test. Please be aware that if this service is preformed during your examination, a refraction charge of $30.00 will be collected today in addition to your co-payment**.**

ACKNOWLEDGEMENT

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. I understand the co-pay is separate from, and not included in the refraction fee. I understand I will only be charged this fee when a refraction is done during my examination.

____________________________________ ______________________

Patient Signature and Name **Date**

Notice of Privacy Practices:

I have been given the opportunity to review the Notice of Privacy Practices (HIPPA).

Signature __________________________ **Date** ______________________________