SEE 20/20 OPTOMETRY

MEDICAL INSURANCE BILLING

It is important that you read and acknowledge our Policies and Procedures in full.

Policies and Procedures

Co-Payments will be collected at the time of the service. Professional fees, service fees, co-payments and deductibles are NOT refundable.

As the patient/guarantor, it is your responsibility to know your insurance benefits and to provide our office with accurate and current insurance information. If your specific insurance plan requires a referral, it is your responsibility to obtain the referral from your primary care provider. If you arrive without a referral, we will do our best to obtain one for you but can not guarantee the referral will be issued. You have the option of rescheduling or to pay in full at the time for services rendered.

If you are a Medicare patient with a secondary insurance to your Medicare plan, it is your responsibility to provide both insurance cards. If the office does not have the proper information for the secondary insurance, the secondary will not be billed.

For PPO insurance plans. We will bill your insurance as applicable, however, you are ultimately responsible and liable for any fees and costs not covered or paid by your insurance. Questions about non-payment should be directed to your insurance company.

We follow your benefits guidelines given to us at the time of your appointment. Benefits and fees are subject to change per your insurance payment schedules. Some services or all services could be applied to deductible and you are responsible for any amounts due after insurance claims are submitted. We will review your explanation of payment from your insurance and review what you have paid to our office. **You may receive a bill for services not paid for or applied to your deductible from your insurance.**

Patient Responsibility

I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes medical service or visit, testing or screenings ordered by the doctor or staff.

I understand that while my insurance may confirm benefits, confirmation of benefits is not a guarantee of payment and I am responsible for any unpaid balance.

I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network, usual and customary limits, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.

I agree to inform the office of any changes to my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

If I am a Medicare patient, I understand that I need to provide the office with both my Medicare and secondary insurance cards. If the office does not have the proper information for the secondary insurance, the secondary will not be billed and I agree to pay for the remaining balance.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or required by law. I have the right to revoke this Consent, in writing, signed by me. However, such a revocation shall not affect any disclosures already made in compliance with my prior Consent. See 20/20 Optometry provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____	_____	_____
Printed Patient Name (or Guardian)	Patient or Guardian Signature	Date