Eye Care & Surgery Associates

Print Patient Name: _____ Date of Birth: _____

FINANCIAL AND MEDICAL POLICY (APPLICABLE TO ALL PATIENTS)

Your health insurance policy is an agreement between you and your insurance carrier for reimbursement of fees paid to the physician and is usually not designed to pay the entire fee. Regardless of your medical coverage, we rely on you for settling your account. You are ultimately responsible for all office and surgery fees relating to your care. If we have a problem collecting from your insurance company, we will ask you to become involved. Whatever service your insurance does not cover, you will be responsible for payment.

- All copays will be collected at the time of service. Copays are a requirement of your insurance company. If you are unable to pay your copay at the time of service, we will reschedule your appointment.
- Self-pay patients will be required to pay at the time of service. If you have any questions on how much your appointment will cost, the billing department can quote you a range for the service. If you cannot pay in full at the time of service, we will gladly set you up on a payment plan where we will run your credit card each month.
- Specialty Lens for Cataract Surgery are often available. Toric and ReSTOR lenses are considered elective and are not covered by insurance. The doctor's fee is required to be paid before the surgery date. The facility will collect their cost on surgery day. If you need to make payments for the elective lens, we will postpone your surgery until the lens is paid in full.

These policies are based on the guidelines of your insurance companies and our collections policy. Eye Care & Surgery Associates is contractually obligated to follow them. Eye Care & Surgery Associates makes every effort to submit claims correctly to ensure that we are in compliance with our contracted insurance carriers AND that you do not receive unexpected medical bills for uncovered services.

I authorize the release of any medical information necessary to process this claim and I authorize the release of payment for medical benefits to my physician.

_____ _____

Patient/Guardian Signature Date

CONSENT TO CALL

I consent to receiving auto-dialed and/or pre-recorded messages, emails, text messages or other electronic communication from my healthcare provider and/or agents, including without limitations, any account management companies, independent contractors and/or debt collectors for any reason by using any telephone number, cellular or otherwise, provided by me to my medical provider.
This gives us permission to leave you a voicemail regarding appointments, testing results and any other pertinent information.

_____ _____

Patient/Guardian Signature Date

□ Decline Consent to Call