Commonwealth Family Eye Care, PLC

1501 Sam's Cir
Chesapeake, VA 23320
Ph: (757) 549-2020
Fax: (757) 548-0088

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received and read a copy of Commonwealth Family Eye Care, PLC **Notice of Private Practices**

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Signature of patient or parent, if minor Date

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Name of patient or parent, if minor Date

FINANCIAL POLICIES

We are dedicated to providing the best possible care and service to you and believe that your understanding of your financial responsibilities is an important element of your relationship with our practice. In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy.

Your insurance policy is a contract between you and your carrier. The doctor is NOT involved. All health plans are not the same and do not cover the same services at the same payment schedule. Due to the large numbers of plans we deal with, we cannot assure you that any specific amount of any charge will be covered. **Your involvement in knowing what your insurance covers is important and we encourage you to become familiar with your plan.** This information is best obtained by calling your insurance company.

If your insurance requires a referral, it is your responsibility to obtain that referral. Please check with your carrier to see if your visit to a specialist requires a referral. If your policy stipulates that you need a referral and you do not have one, we will give you the option of rescheduling your visit or not using your insurance. Again, this is your contract with the insurer and we have little ability to impact it.

We file insurance claims for all patients with whom we have a participating agreement. We would like to participate with and accept assignment on ALL insurances, but we cannot due to limitations BY THE INSURANCE COMPANIES. We have asked to be included in a number of networks, but if we do not participate it is usually because of circumstances beyond our control. This is always a concern for us and we work to increase our options and serve on all panels that would like to have our care. **Please be sure that your insurance will permit you to see us.** This is especially true for PPO and HMO networks.

Deductible, co-payment and "non-covered" amounts are the responsibility of the patient. They are due at the time of service. **Please do not ask us to waive co-payment or deductibles, as this is a violation of your insurance contract** and an embarrassment to all.

Payment is due in full when services are rendered, unless arrangements are made in advance. For your convenience, we accept most credit cards.

Continued on Reverse

AUTHORIZATION AND RELEASE

I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

LATE CHARGES

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% (18.00% APR) or at least a minimum service charge of $2.50 on the unpaid balance will be assessed each month. I realize that failure to keep this account current may result in this office being unable to provide additional services except for emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay for collection costs and reasonable attorney fees occurred in attempting to collect on this amount or any future outstanding account balances.

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Signature of patient or parent, if minor Date

TRICARE/CHAMPUS PATIENTS

The official policy of TRICARE/Champus states that certain services may not be a covered benefit. Only examinations for eyeglasses and eye disease services are covered. We are required to collect usual and customary fees for all non-covered services. In addition, any **medical** or **vision** insurance is primary (must be used first) to TRICARE. The following services may not be a covered benefit through TRICARE/Champus:

1. Contact lens evaluations.
2. Visual field evaluations.
3. Retinal photography.

By signing this form below, you agree to be financially responsible for any non-covered fees through TRICARE/Champus.

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Signature of patient or parent, if minor Date

MEDICARE PATIENTS

Medicare will only pay for services that it determines to be "Reasonable and Necessary" under Section 1862(A)(1) of the Medicare Law. If Medicare determines that a particular service, although it would be otherwise covered, is not "Reasonable and Necessary" under Medicare program standards, Medicare will deny payment for that service. I believe that in your case, Medicare will deny payment for all services because **routine eye care is not covered**. This serves as notice that he/she believes that in my case, Medicare is likely to deny payment for the service identified above for the reason stated. If Medicare denies payment, I agree to be personally responsible for payment.

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Signature of patient or legal guardian Date