Clinic Policies and Procedures

ALAMEDA EYE CENTER

1. **Payment Due**: I understand that payment is due at check-in on the day of my appointment.

2. **Co-pay, Co-insurance and Deductibles.** It is my responsibility to know what my co-pay, co-insurance and deductibles are, and my obligation to pay this at the time of service.

3. **Billing Fee:** If I am not able to pay my co-pay, deductible or co-insurance portion at the time of service my appointment may be cancelled or rescheduled.

4. **Insurance Coverage**: I acknowledge that the insurance cards I have presented are current and accurate.

5. **Non-covered Services**: I understand that some services may be considered non-covered services by my insurance plan. I understand that it is my responsibility to know what my insurance does or does not cover and I understand that I am financially responsible for paying all non-covered services.

6. **Denied Charges**: I understand that some charges may be denied by my insurance carrier as not medically necessary and will not be paid by my insurance carrier. I understand that my physician feels these services are needed whether my insurance carriers deem them payable or not and that I am obligated to pay for these services in full.

7. **Refractions**: Refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary in order to write a prescription for glasses or contact lens. Medicare and most medical insurance do not cover the fee for refractions ($50). I understand that I am responsible for this fee and it is payable at the time of service.

8. **Participating Insurance Plans:** If the practice is not a participating provider in my insurance plan, I will be responsible for filing my own claims and I will be responsible for paying in full at the time of service.

9. **Returned Checks & Past Due Accounts:** Returned checks will be subject to collection charges, penalties and interest.

   All accounts are considered past due if not paid within 90 days of service. Past due accounts may result in collection turnover and are subject to penalties and interest, or the refusal of future appointments until old balances have been paid in full. The practice does not accept post-dated checks.

10. **Medicaid:** The practice only accepts patients that have only Medicaid coverage if they are referred by another Medical Provider for a medical condition. The practice does not participate with Medicaid for routine vision services. I understand that I am responsible for my copay at the time of service and if I have exceeded my yearly allotted visits that I am responsible for paying for my visit in full at the time of service.

11. **Vision Plans**: The practice does not participate in any vision plans at this time.

12. **Medical Plans that have Vision Benefits**: Please be advised that some medical plans do have routine vision benefits; however, sometimes these vision benefits are with a different carrier than your medical plan. We may be participating providers with your medical plan but not your vision plan. Please contact your carrier to verify your benefits and whether the practice is a provider for both your medical and vision plan.

13. **No Show Appointments:** All appointments that are not cancelled within 24 hours of appointment time are subject to a $50.00 no-show fee. This fee must be paid before we can reschedule your appointment.

14. **Surgery Charges:** The practice will make every effort to determine your insurance benefits and to relay to you what you will owe for surgery charges, but please keep in mind that this is just an estimate. Please be

aware that when surgery is performed, you may incur addition charges (in addition to the surgeon's fees) from the surgery facility, anesthesiologist, laboratory or radiologist.

15. **Prior Authorizations**: Some insurance plans require you receive a prior authorization for services by a specialist, please review your policy to see if there is such a requirement and obtain this authorization prior to your visit with our clinic.

16. **Notice of Privacy Practices:** I acknowledge that I have been made aware of the clinic's privacy practices. I understand a copy of the Notice of Privacy Practices is available at my request.

I acknowledge that I have read and understood the above policies and procedures in its entirety and agree to abide by them.

Patient Name (Print): _____

Patient Signature: _____

Date: _____