BROWN
EYE CARE ASSOCIATES
Ophthalmology and Ophthalmic Surgery

R. Stephen Brown, M.D.
Christopher D. Brown, M.D.
Andrew C. Brown, M.D.

Office Policy

Refractions

A Refraction is the process of determining your eyeglass or contact lens prescription. It is not possible to provide you with an accurate eyeglass or contact lens prescription without performing a Refraction. Please be advised, **Medicare** and most other insurance companies **DO NOT PAY** for this service. As a courtesy to our patients, if you have a refraction we will bill your insurance. However, should your insurance policy not pay for a refraction, you will be billed for this service.

Referrals

If your health insurance plan requires a referral from your Primary Care Provider (PCP) for your specialist visit, you are required to contact your physician to obtain this referral. Failure to obtain this referral may result in rescheduling your appointment until it is obtained or payment in full by the patient at the time of your visit.

Co-Payments,Deductibles/Coinsurance

Payments are due at the time of the office visit. Our contracts with insurance companies require us to collect your co-pay at the time of service. We accept all forms of payment. In the event a personal check is returned unpaid from your bank, your account will be charged with a returned check fee of $35, and your account will be placed on a ***"credit card/cash only"*** basis. Late co-pays are subject to an additional $25 service fee if not paid at time of service.

Contact Lens Services

Contact Lens Services are not covered by medical insurance policies. Patients are responsible for all costs associated with Contact Lens Services.

No Show Fee

Please give a minimum of 24 hours' notice to cancel or change an appointment. Not showing for your appointment and not cancelling in advance denies another patient the opportunity to have an appointment at that time. A $50 fee will be charged without advance notice.

Outstanding Balances

In the event that your account is forwarded to Collection you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33 1/3% of the debt, and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

By signing below, I acknowledge that I am aware of Brown Eye Care Associates' policies.

Patient Name (please print): _____

Signature: _____ ***Date:*** _____

Signature on File, Assignment of Benefits, Financial Agreement

_____

Patient Name (Print)

1. **Medicare:** I request that payment of authorized Medicare benefits be made on my behalf to Brown Eye Care Associates for services furnished me by Brown Eye Care Associates. I authorized any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is added in item 9 of the CMS-1500 form or elsewhere on other approved claim forms my signature authorizes releasing the information to the insurer or agency shown. Brown Eye Care Associates accepts the determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. **MediGap:** I understand that if a MediGap policy or health insurance is indicated in item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. Request that payment of authorized secondary insurance benefits be made on my behalf to Brown Eye Care Associates, if possible, or otherwise to me.

3. **Release of Information:** Brown Eye Care Associates may disclose all or any part of my medical record and/or financial ledger including information regarding alcohol or drug abuse, psychiatric illness, communicable disease or HIV, to any person or corporation which is or may be liable or under contract to Brown Eye Care Associates for reimbursement for services rendered, and (2) any health care provider for my continued care. Brown Eye Care Associates may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education and/or medical research, for the collection of statistical data or pursuant to State or Federal Law, statue or regulation. A copy of this authorization may be used in place of the original.

4. **Other Insurance:** I understand that Brown Eye Care Associates maintains a list of healthcare service plans with which it contracts. A list of such plans is available from the business office and that Brown Eye Care Associates has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Brown Eye Care Associates if I belong to a plan that does not appear on the above mentioned list or if I do not follow the guidelines of my insurance by getting a referral if required to.

5. **Non-Covered services:** I understand that Brown Eye Care Associates' contracts with health care service plans relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans to be not covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Brown Eye Care Associates to obtain necessary health care service plan authorizations.

6. **Financial Agreement:** I agree that in return for the services provided to the patients by Brown Eye Care Associates, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Brown Eye Care Associates for payment. If an account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, are hereby assigned to Brown Eye Care Associates. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Brown Eye Care Associates. However it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

_____ _____

Patient Signature or Authorized Party **Date**