Eye Care Specialists Of Florida

Caring for you, not just your eyes

FINANCIAL POLICY

In compliance with Federal Consumer Protection Act, Eye Care Specialists of Florida, LLC is furnishing you with information regarding your financial responsibilities. We are pleased you have chosen Eye Care Specialists of Florida, LLC for your specialty eyecare needs. We ask that you take the time to read our policy so we can avoid any misunderstandings. If you have any questions, our staff will be happy to discuss them with you. All copays, co-insurances, and deductibles are due at the time services are rendered. After 30 days, all unpaid balances will be transferred to your responsibility. Even though we may participate in your insurance program, some charges may always be your responsibility. It is always your responsibility to make sure appropriate authorization has been obtained for procedures when necessary. If your insurance company refuses to pay for services due to lack of an authorization, you will be responsible for these non-covered charges. It is always your responsibility to understand the coverage your insurance program provides and its referral authorization process. Please understand that our office cannot accept responsibility for pay or non-payment on your insurance claims. Questions about coverage and benefits are between you and your insurance company. For patients not covered under any billable plans, we require full payment at time of service. We will furnish you with a month statement of your account showing the amounts billed to you and any payments received on your account Payment can be made in cash, check, and/or any major credit card. If a check is returned to our office for lack of sufficient funds a fee of $25.00 will be added to the amount of the check and will be deemed payable immediately to be paid in full by cash or credit card. Payment for services which have been billed to you are due in full within 30 days of receipt of your billing statement. If you fail to pay within a reasonable amount of time or cooperate with the terms of an agreement upon payment schedule, your account may be turned over to an outside agency for resolutions. Overpayments to your account will be refunded to you within 30 days of overpayment, provided your account has a credit balance. If there is an outstanding balance due on your account, all credits will be applied to that balance prior to issuing a refund.

ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with _____ and assign directly to Eye Care Specialists of Florida, LLC, Saira A. Choudhri, MD, all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize Eye Care Specialists of Florida, LLC to release all information necessary to secure the payment of benefits and authorize the use of this signature on all insurance submissions. Furthermore, a copy of this assignment is considered valid in place of the originals. In signing this form, I consent to treatment by Eye Care Specialists of Florida, LLC, Saira A. Choudhri, MD, for my illness and/or health evaluation including but not limited to Fundus Photos, Laboratory Procedures, Medications, and Office Procedures. I acknowledge and agree that no guarantees have been made to me as to the results or outcome of my medical care and I understand that state law requires providers to report certain communicable disease to the Health Department. I also acknowledge that you may use and disclose protected health information (PHI) to carry out treatment, payments, and health care operations. I authorize Eye Care Specialists of Florida, LLC, Saira A. Choudhri, MD or its appointed representatives to e-mail and/or call the numbers provided in reference to any items that assist the practice in carrying out TPO, such as appointment reminders. Eye Care Specialists of Florida, LLC may also mail to my home any items that assist the practice in carrying out TPO.

Print Patient Name: _____

Patient/Guardian Signature: _____ Date: _____