Eye Physicians of Central Florida

A Division of Florida Pediatric Associates, LLC

Financial Policy& Privacy Notice

Regarding insurance plans where we are a participating provider: Although we have contracted with your insurance company to provide care to their clients, your insurance policy is a contract between you and your insurance company. All co-pays and deductibles are due prior to treatment, along with a valid referral from your primary care provider, if your insurance plan requires it. Please note that if you require treatment that is not deemed medically necessary or is not a covered service with your insurance carrier, you will be responsible for payment in full prior to that treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the paragraph below.

Regarding insurance plans where we are <u>not</u> a participating provider: You are responsible for payment of your first office visit in full. We may accept assignment of insurance benefits after your second visit. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, you will be responsible for payment within 30 days upon receipt of the bill. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. You are responsible for these charges.

Medicare: I request that payment of authorized Medicare benefits be made on my behalf to **Eye Physicians of Central Florida**, for the services furnished to me by **Eye Physicians of Central Florida**. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (formerly Health Care Financing Administration) 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. **Eye Physicians of Central Florida** accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

Medigap: I understand that if a Medigap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to **Eye Physicians of Central Florida**, if possible or otherwise to me.

Release of Information: Eye Physicians of Central Florida 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 (1) which is or may be liable or under contract to **Eye Physicians of Central Florida** for reimbursement for services rendered, and (2) any health care provider for continued patient care. **Eye Physicians of Central Florida** 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, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

Minor Patients: The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For an unaccompanied minor, non-emergency treatment will be denied unless payment arrangements have been made in advance.

Returned Checks: If your bank returns your unpaid check for any reason, such as insufficient funds or closed account, you will be charged $50. Payment must be made prior to your return to the office and we may not accept any more personal checks.

Missed Appointments: Eye Physicians of Central Florida requires 24 hour advance notice for all missed, cancelled or rescheduled appointments. Failure to notify our office will result in a **<u>$50 fee</u>**. Emergencies will be considered on a case by case basis for waiver of this fee. Excessive missed appointments will result in discharge from the practice.

Collections: You may be dismissed from the practice if you fail to meet your financial responsibilities and/or we must use a collection agency to bring your account up-to-date. If it is necessary to turn the account over to collections and you wish to return to the practice, you will be responsible for all charges, including those incurred to collect the amount owed, i.e. collections agent's fees. Your account must be paid in full before you are able to return to the office.

Notice of Privacy Practices: Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you in the process of providing treatment, seeking payment or carrying out our own health care operations. This notice contains a Patient Rights section describing your rights under the law. A copy of the current notice in effect will be posted. Each time you receive treatment or healthcare services you may request a copy of the current notice.

_____	_____
Patient Name (print)	Parent or Guardian Name (print)
_____	_____
Patient Signature	Parent or Guardian Signature (if minor)
_____	
Date	(Update 08.03.18)