CLEAR VIEW EYE ASSOCIATES

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Patient Responsibility Form

Thank you for choosing Clear View Eye Associates, P.C. (further referred to as CVEA) as your eyecare provider. We are committed to providing you with the highest quality healthcare. Therefore, we ask that you read and sign this binding agreement to acknowledge your understanding of our patient policies.

1) Responsibility of Medical Care

- All responsibility further described belongs to the Patient who is receiving medical services or the Responsible Party for all patients under the age of 18 (together further referred to as the PT/RP). **All persons under the age of 18 must be accompanied by a parent/legal guardian or by an adult who has obtained written consent for the child's treatment from the parent/legal guardian to be considered the Responsible Party.**

2) Financial Responsibility

- **The PT/RP is ultimately responsible for the full payment for all treatments and services.**
- **Complete payment of all charges is due at the time of service.**
- As a courtesy, CVEA will check and bill the patient's insurance. The PT/RP is responsible to provide CVEA with all current and correct information regarding their insurance including presenting all current insurance cards prior to each visit. It is the responsibility of the PT/RP to know their plan coverages and benefits, it is impossible for CVEA to know this detailed information for every visit.
- The PT/RP is responsible for payment of copayments, deductibles, and payments for all other procedures, treatments, services and charges not covered by their insurance (including the refraction) at the time of service.
- The PT/RP is responsible for payment of co-insurances and deductibles within 30 days from receipt of bill. CVEA accepts payment in cash, personal check, VISA, MasterCard. There is a $25 service charge for each returned check.
- **If CVEA does not receive payment from the insurance company within 60 days from the date of service, the PT/RP will be expected to pay the balance in full.** After the balance is paid, CVEA will give the PT/RP an itemized receipt, it is the PT/RP's right to present this to their insurance company and request reimbursement from them. The outcome is solely dependent on the insurance company. This process is between the PT/RP and their insurance company.
- PT/RPs with an outstanding balance of 60 days past-due must make arrangements to pay their balance in full prior to scheduling any future appointments.
- PT/RPs with balances over 90 days past-due will be considered seriously delinquent and will be filed with small claims court for immediate payment in full. The PT/RP is responsible for all costs of collection. At the discretion of CVEA the PT/RP may be asked to leave the practice.
- CVEA does realize that there are extenuating circumstances and that people can have financial difficulties. We are willing to work with you to help you resolve any problems; please call our office if there is a problem.

3) Medical Records Transfers

- If there is a request for medical records to be sent to the PT/RP or to another office CVEA reserves the right to charge an administrative fee of $15 (plus shipping where applicable). This is to be paid in full at the time of the request and is solely the responsibility of the PT/RP. Please allow up to two weeks for processing.

PT/RP Initials _____ Date _____

4) No-Shows/Late Cancellations

- Our goal is to provide patients with the highest quality medical care in a timely manner. Appointments are in high demand and no-shows and late cancellations inconvenience other patients who need care, missed appointments are also a loss of revenue for our practice. As a courtesy, CVEA will attempt to confirm all appointments via automated email, text message and/or phone call one day before the appointment but please understand that this is not always possible. At this time the PT/RP will have an opportunity to either confirm or make changes to the appointment. **It is ultimately the responsibility of the PT/RP to know and keep all appointments.**
- If it is necessary to cancel or reschedule the appointment, **we require 1 business day advance notice**.
- A no-show is any missed appointment without a minimum 24 hours notice. Cancellations less than 24 hours in advance are also considered as a no-show. Arriving more than 15 minutes late without communication to the office will also be considered a no show. All no-shows are recorded in the medical record of the patient.
- **A no-show fee of $40 will be charged to the patient's account and is the responsibility of the PT/RP to pay in full.** All no-show fees must be paid in full before any future appointments can be scheduled.
  CVEA reserves the right to discharge any patient with persistent (>3) no-shows in their record.

5) Responsibility of Referrals

- The PT/RP's insurance may or may not require a prior authorization (referral) from their Primary Care Physician (PCP) for the services which they are receiving. **It is solely the PT/RP's responsibility to know the policies of their insurance company.** CVEA is not required to know or provide any information regarding these policies.
- **If necessary, it is solely the PT/RP's responsibility to obtain the referral prior to the date of the service and to present the referral to CVEA prior to or on the date services are rendered.**
- If the PT/RP does not have a referral ready at the date of service and still choose to receive services from CVEA they will be held responsible to pay any charges not covered by their insurance company for any reason.
- If the patient is seen without a referral it is the PT/RP's responsibility to obtain a back-dated (retroactive) referral as necessary per their insurance company. CVEA is not responsible for attaining this referral. Please also be aware that the PCP may refuse to issue a back-dated (retroactive) referral, this is their decision. In such cases the PT/RP is responsible to pay any charges from CVEA for all services rendered.
- If the insurance company chooses not to accept a back-dated (retroactive) referral for any reason, it is the PT/RP's responsibility to pay any charges from CVEA for all services rendered.

6) Outside Orders

- If a complete pair of eyeglasses or sunglasses has been purchased online and the patient needs the frame adjusted, fitted, or repaired CVEA reserves the right to apply a $20 fee to be paid at the time services are rendered. If a Pupil Distance (PD) measurement or any measurement that is not part of the eyeglass prescription is requested at the discretion of the PT/RP a $15 charge will be applied. The Optician will inform the PT/RP of any charges. The PT/RP is responsible for all such charges that are applied prior to services being rendered.

7) Dilated Eye Examination

- Dilation is a medical procedure which allows the doctor to use eye drops to temporarily enlarge the pupils for a more extensive view of the retina (back of the eye). With dilation, the doctor has the opportunity to evaluate and diagnose eye health problems often before symptoms occur. **It is recommended that all new patients are dilated and dilated again every 2-4 years thereafter unless certain conditions require closer monitoring.** Some patients may experience light sensitivity and blurred vision for 2-6 hours. CVEA will provide the patient with a disposable pair of sunglasses if necessary after the procedure. The patient may experience difficulty driving, if so it is the responsibility of the patient to make appropriate transportation arrangements. In rare instances, patients may experience pain or other side effects. If this should occur, please seek medical attention immediately. **Please be certain to inform our doctors if you are pregnant or nursing at the time of the procedure. If you have any health conditions that may affect your response to this procedure or have any questions regarding dilation, please consult our doctors for additional information.**

Acknowledgement

I, the PT/RP, have read and fully understand the Patient Responsibility Form of Clear View Eye Associates, P.C. and agree to all the terms and conditions contained therein.

I hereby authorize and direct payment of my insurance benefits to Clear View Eye Associates, P.C. on my behalf for any service provided to me. I understand that I am fully responsible for payment of all charges not covered by insurance for any reason and agree to pay all charges as necessary.

I hereby authorize Clear View Eye Associates, P.C. to release medical and other information acquired in the course of my examination/treatment to the necessary insurance companies, governmental agencies, third party payors, and/or other healthcare entities as needed to substantiate payment for all medical services as well as information required for precertification, authorization or referral to other medical providers.

Clear View Eye Associates, P.C. respects patient confidentiality and will only release patient health information in accordance with the State and Federal Law.

This document is a binding agreement and does not expire. This agreement applies to all Clear View Eye Associates, P.C. locations.

To be completed by the **Patient (PT)**:

Name (print) _____ Today's Date _____

Signature _____

Date of Birth _____

To be completed by the **Responsible Party (RP)**:

Patient's Name (print) _____ Today's Date _____

Patient's Date of Birth _____

Name of the Responsible Party (print) _____

Signature of the Responsible Party _____