Office Policies and Procedures

1. Our office values your time and dedication in keeping your medical appointment. So that we may accommodate other patients we would greatly appreciate it if you are not able to make your appointment that you notify us at least 24 hours in advance. If you believe that you will be arriving more than 15 minutes late to your scheduled appointment, please call our office at (305)-891-0331 to inform the staff.

2. If you arrive more than 15 minutes after your scheduled time with out calling to notify the staff your appointment may re-scheduled.

3. Being that this is a medical specialist office, if you are on an HMO insurance carrier we are **not authorized** to see you with out a referral from your primary care physician.

4. Patients are responsible to know if their insurance company requires an authorization / referral for an office visit. You're responsible to bring the authorization/referral with you to your appointment and it must be made out to the right doctor. If you do not have your authorization /referral at the time of your visit your appointment may be re-scheduled.

5. It is the patient's responsibility to know their co-payments and deductible amounts. All co-payments and deductibles will be collected at the time of your visit. This also includes co-insurance amounts (i.e. 10%, 20%). With the exception of Medicare, it will be our office fee, you will be reimbursed if a refund is due.

_____ _____

Patient/ Guardian signature Date

_____

Name of Patient

Refraction Policy

Patient Name_____

Insurance_____ ID No_____

Certain services performed in our office are unfortunately not covered by some insurance companies. One common procedure is a **refraction**. A refraction is conducted when the ophthalmologist wants to determine whether corrective lenses such as glasses or contact lenses may improve your vision.

Medicare does not cover this service nor does any other HMO affiliated with Medicare. Even if you have Medicare and a secondary/supplemental insurance, this service is still not covered. The majority of non- Medicare based HMO's follow the Medicare guidelines so they also will not cover this service.

Because the ophthalmologists in this office feel strongly that patients should be refracted once a year to ensure no vision changes, they provide each patient a $40.00 discount. Although the charge for this service is $65.00, as a courtesy to each patient, **a refraction only costs $25.**

Should you choose to have the refraction done, the charge is payable, along with your co-pay, at the time services are rendered. This decision is solely up to the patient and you are not obligated to have this service conducted in our office.

Please choose if you would like to receive this service. If you have any concern about your HMO covering this feel free to inquire at the window with one of the staff. Thank you.

( ) 1. YES, I would like to be refracted. I understand that it is not covered by Medicare and most other insurances companies. I agree to be personally responsible for payment of this service.

( ) 2. NO, I would not like to receive this service in your office at this time.

_____
Patient Name

_____ _____
Patient Signature Date

Name:_____ Male____ Female____
Last First MI

Address:_____

City_____ State_____ Zip_____

Date of Birth:_____/_____/_____ Place of Birth _____

Social Security No.:_____-_____-_____ Home Tel:_____

Marital Status: Single___ Married___ Divorced___ Widowed___

Name of Spouse:_____ Phone:_____

Nearest Relative:_____ Phone:_____

***IN CASE OF EMERGENCY**:

Contact:_____Relationship_____

Telephone No.:_____

Who Referred you to our office?_____

PERSONAL PHYSICIAN_____PHONE_____

CHIEF COMPLAINT:_____

EMPLOYER'S NAME:_____

EMPLOYER'S ADDRESS:_____

EMPLOYER'S PHONE NO._____

MEDICAL INSURANCE CARRIER:_____

INSURANCE MEMBER ID #:_____ GROUP #:_____

MEDICARE #:_____ MEDICAID #:_____

I understand that my insurance is a contract between myself and my insurance carrier. I understand that any balance on my account for any professional services rendered is solely my responsibility. I certify this information is true and correct, to the best of my knowledge. I will notify you of any changes in my health status of the above information. I authorize any holder of medical or other information about to release to the Health Care Financing Administration to any information needed to determine these benefits for related services.

I understand and agree that I may be requested to pay a fee up to $25.00 for the refractive portion of my examination if not covered by my insurance carrier.

X_____ DATE_____