

Patient Responsibility

I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical service or visit, routine examination, refraction, testing, contact lens services and any other screening ordered by the doctor or staff.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID card and my secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or as required by law. I have the right to revoke this Consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior Consent. LLCEA/PS provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Printed Patient Name (and Guardian Name if applicable)

Patient or Guardian Signature

Date

LLCEA/PS Witness

I give permission to communicate my Private Healthcare Information to:

Name

Relationship

Name

Relationship

Name

Relationship

Our office does not make the rules. They are determined by your specific medical insurance or vision plan.



It is important that you read and acknowledge our Policies and Procedures in full.

Policies and Procedures

Payment in full for services and products are due at the time services are performed or products are ordered. As the patient/guarantor, you are financially responsible for any fees and costs associated with any services or products you receive from our office. This includes any medical service or visit, routine examination, testing, contact lens services and any other screening ordered by the doctor or staff.

Co-payments will be collected at the time of service. Professional fees, services fees, co-payments and deductibles are NOT refundable. There will be a \$20 fee for returned checks.

As the patient/guarantor, it is your responsibility to know your insurance benefits and to provide our office with accurate and current insurance information. If your specific insurance plan requires a referral, it is your responsibility to obtain the referral from your primary care physician. If you arrive for an appointment without a referral on file, you have the option to reschedule the appointment or to pay in full for all services rendered.

If you are a Medicare patient with a secondary insurance to your Medicare plan, it is your responsibility to provide both insurance identification cards. If the office does not have the proper information for a secondary insurance, the secondary will not be billed.

We will bill your insurance as applicable, however, you are ultimately liable for any fees and costs not covered or paid by your insurance. Questions about non-payment should be directed to your insurance company.

If you are unable to keep your scheduled appointment, we ask that you give adequate notice (24 hours when possible, or prior to appointment time on the same day in an emergency situation) so that we may open your reserved time for another patient. If you miss two appointments without prior cancellation, you will be required to pay a \$35 deposit prior to scheduling further appointments. This is a good-faith deposit to reserve your appointment time. When the appointment is kept, this \$35 fee will be applied to your office visit fees or refunded as appropriate. If the appointment is missed without proper notice of cancellation, the deposit becomes non-refundable.

Medical vs. Vision Insurance

Medical Insurance: when a medical condition exists such as (but not limited to) cataracts, glaucoma, dry eyes, diabetes, high blood pressure, or any other condition related to the health of the eye, it will be necessary for the doctor to perform a full and comprehensive ocular health exam. This exam may include further testing beyond the scope of a routine eye exam. With a medical diagnosis, your exam and testing will be billed to your medical insurance and you will be responsible for any co-pays, deductibles and/or co-insurance as dictated by your specific plan. If you are diabetic, your exam will be billed to your medical insurance without exception.

Vision Care Insurance: vision coverage for a routine examination is designed to provide a screening evaluation of the eye to determine a prescription for glasses only. This evaluation is not a comprehensive ocular health examination and excludes any testing to diagnose, evaluate and follow medical issues. This evaluation also does not include a contact lens evaluation or any fees associated with contact lenses.

Refractions: a refraction is the portion of the examination process wherein the doctor or technician places various lenses in front of your eyes to determine your best corrected vision for your spectacle prescription. This service is considered to be a non-covered service by Medicare and most secondary insurance plans. The fee for this service is \$35 and is collected when a refraction is performed whether or not you have had a change in your prescription. A spectacle prescription is valid for two years from the date of the refraction; you will need to have refractions as part of your exam in order to maintain a current prescription.

Contact Lenses: contact lens services are considered to be elective and therefore not covered by medical insurance, and often not covered by vision insurance. A contact lens prescription is valid for one year from the date of issue. In order to maintain a current contact lens prescription, you must have annual contact lens evaluations with your doctor. Payment for a contact lens evaluation, whether performed independently or as part of your comprehensive eye exam, is expected at the time of service. A separate contact lens agreement will be signed prior to a contact lens fitting or refitting.

GARY J LEVIN MD, PC
d/b/a LEVIN LUMINAIS CHRONISTER EYE ASSOCIATES
PRO-SPECS, INC.

PRIVACY PATIENT CONSENT FORM/SIGNATURE ON FILE

Levin Luminaiis Chronister Eye Associates and Pro-Specs (LLCEA/PS) Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The term of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations, and/or as required by law. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in compliance with your prior Consent. LLCEA/PS provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands:

- Protected health information may be disclosed or used for treatment, billing, health care operations and/or as required by law.
- LLCEA/PS has a Summary Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- The patient has the right be informed when their PHI is believed to have been breached.
- The patient is allowed to restrict PHI disclosure to their health plan if the patient is agreeing to pay out of pocket and in full for services rendered.

(rev 9/23/13)

The doctors and staff of Levin Luminaiis Chronister Eye Associates appreciate your compliance with these policies and procedures. We strive to provide the best eye care available to you. We are happy to discuss any questions or concerns you have about these policies.