

The Eye Center

Medical & Surgical Eye Care

Laura Muller M.D.

727-216-2020

Financial Policy

As a courtesy to you, our patient, our office will file your insurance(s) for you. However, since the coverage is a contract between you and the insurance company, it is ultimately the patient's responsibility to ensure that services are paid in a timely manner. If your procedure is a non-covered benefit, according to your insurance policy, it becomes an expense billable to you.

If you are a member of an **HMO policy**, which requires an authorization from the primary care physician, **IT IS THE PATIENT'S RESPONSIBILITY** to obtain any and all *PRIOR TO YOUR VISIT*. If the authorization is not in our office at the time of service, it may be necessary to reschedule your visit.

All **Co-Payments** are due at the time of service and will be collected at the front desk when you sign in. All **Coinsurances and/or Deductibles** are also due at the time of service. Payments can be made by check, cash or credit card (Visa & Master Card are accepted). If a check is returned by your bank for any reason, you will be charged a \$39.00, **Returned Check Fee**, which will be added to your account. This charge along with the amount that was returned from your bank must be paid in full by cash, credit card, or money order **PRIOR** to any follow up visits.

If you are a **PRIVATE PAY PATIENT** (with no insurance coverage) all fees are due and payable at the time services are rendered, unless prior arrangements have been made with our billing department.

If you are a **PARENT /LEGAL GUARDIAN OF A MINOR**, it is your responsibility who is seeking treatment for the child to ensure that payment is rendered accordingly. Minors **MUST** be accompanied by a Parent/Legal Guardian at all visits.

For all **MEDICAL RECORDS REQUESTS**, the applicable form will need to be completed and signed by the patient. To cover the costs of copying and mailing, there will be a fee for medical records requests that are furnished to you. No charge will be assessed for a request to another physician. Our office will only release medical records pertaining to services performed by The Eye Center. Please provide our office 24-48 hour advanced notice when requesting records.

By signing below, I understand that **I AM RESPONSIBLE FOR PAYMENT OF SERVICES PROVIDED**. If for any reason I am delinquent in my payments, I will be responsible for the Collection Fee of 30% and the outstanding balance on my account, plus any attorney's fees.

I ACKNOWLEDGE RECEIPT OF THIS FINANCIAL POLICY AND A COPY SHALL REMAIN IN MY CHART.

RELEASE OF INFORMATION

By signing below, I authorize Laura T Muller, M.D. and The Eye Center to release any information with regard to my treatment, for insurance purposes. I also authorize the above physician to release my information to other physicians or institutions as necessary for my treatment.

I understand that any information given with regard to my treatment shall remain **CONFIDENTIAL** and will be released only as necessary to my care or treatment.

Signature: _____ **Date:** ____/____/____

Print Name: _____