Central Florida Eye Institute

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PATIENT ACKNOWLEDGEMENT

Thank you for choosing us as your health care provider. We are committed to providing you with the best possible treatment. Please understand that payment of your bill is considered a part of your treatment. Your clear understanding of our Financial Policy is important to our professional relationship. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. We are pleased to discuss our professional fees with you at any time, please feel free to ask if you have any questions.

- All patients must complete our Patient Information Card prior to seeing the doctor. This will include the copying of your insurance cards as well as your drivers license.
- Full payment or your contract copay is due at the time of service.
- If you are seen after our regular office hours there will be an additional fee of $28.00.
- There will be a fee of $25 for prescription refills not requested during an office visit.
- We accept cash, checks, Visa/Mastercard/Discover (please note there is an additional surcharge for CC use).
- There will be a fee of $35.00 for returned checks.
- We do offer an extended payment plan with prior credit approval for procedures requiring a larger charge.

Regarding Appointments
When you do not show up for an appointment, it creates an unused slot in our schedule that could have been used for another patient. For this reason there is a No Show charge of $35 for missed office visits and $125 for missed surgical procedures. Additionally, repeated cancellations of scheduled procedures will result in a cancellation fee of $50.00.

Regarding Insurance
We will file Medicare and a supplement, or any other contracted insurance for eligible patients. Please keep in mind that your insurance is a policy between you and your insurance company. We are not a party to that contract and therefore will not become involved in disputes between you and your insurance company. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your responsibility. If your insurance company pays the balance after that time, we will be happy to refund your money.

Regarding Refraction
- A refraction is the process of determining your best corrected vision and if there is a need for corrective eyeglasses or lenses. It is an essential part of an eye examination and is necessary to write a prescription for glasses or lenses.
- A refraction is NOT a covered service by Medicare or most insurance plans. These plans consider a refraction a "vision" service not a "medical" service.
- We will NOT file the charge for refraction with a health insurance plan unless we know that your plan covers the refraction charge.
- Our office fee for a refraction is $55.00 and is collected at the time of service in addition to any copayment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

Regarding Dilation
It may be necessary to dilate your eyes during the course of your eye examination or treatment. Dilation results in sensitivity to light and an inability to see well at close range or distance for a few hours. We provide free disposable sunglasses. Patients should wear sunglasses, be cautious walking and going up or down stairs. We recommend avoiding driving or operating dangerous machinery immediately afterwards. We recommend that someone accompany you to drive you home or that you wait until your eyes return to normal so that you can drive safely.

Regarding Minor Patients
The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/Mastercard/Discover or payment by cash or check is received at the time of service.

Our fees are based on treatment received and have no basis on outcome. Accounts left pending over 60 days will be referred to collections. You will be responsible for payment of any collection fees.

A copy of this signed financial policy is furnished to you upon request.

Signature of Patient or Responsible Party _____ Date _____