BROWN
EYE CARE ASSOCIATES
Ophthalmology and Ophthalmic Surgery

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Office Policy

Refractions

A Refraction is the process of determining your eyeglass or contact lens prescription. It is not possible to provide you with an accurate eyeglass or contact lens prescription without performing a Refraction. Please be advised, **Medicare** and most other insurance companies **DO NOT PAY** for this service. As a courtesy to our patients, if you have a refraction we will bill your insurance. However, should your insurance policy not pay for a refraction, you will be billed for this service.

Referrals

If your health insurance plan requires a referral from your Primary Care Provider (PCP) for your specialist visit, you are required to contact your physician to obtain this referral. Failure to obtain this referral may result in rescheduling your appointment until it is obtained or payment in full by the patient at the time of your visit.

Co-Payments,Deductibles/Coinsurance

Payments are due at the time of the office visit. Our contracts with insurance companies require us to collect your co-pay at the time of service. We accept all forms of payment. In the event a personal check is returned unpaid from your bank, your account will be charged with a returned check fee of $35, and your account will be placed on a ***"credit card/cash only"*** basis. Late co-pays are subject to an additional $25 service fee if not paid at time of service.

Contact Lens Services

Contact Lens Services are not covered by medical insurance policies. Patients are responsible for all costs associated with Contact Lens Services.

No Show Fee

Please give a minimum of 24 hours' notice to cancel or change an appointment. Not showing for your appointment and not cancelling in advance denies another patient the opportunity to have an appointment at that time. A $50 fee will be charged without advance notice.

Outstanding Balances

In the event that your account is forwarded to Collection you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33 1/3% of the debt, and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

By signing below, I acknowledge that I am aware of Brown Eye Care Associates' policies.

Patient Name (please print): _____

Signature: _____ ***Date:*** _____