COMMONWEALTH EYECARE PROFESSIONALS

Commonwealth Eye Care Professionals- Financial Policy
Dr. Kimberly Budri, O.D.

Dear Valued Patient,

Thank you for choosing Commonwealth Eye Care Professionals to serve your eyecare needs. We are committed to building and maintaining a successful physician-patient relationship with you and your family. Your clear understanding of our updated financial policy is vital to our professional relationship.

- **DEMOGRAPHICS**

Patient Name: _____ Date of Birth _____ Sex: Male _____Female_____

Address: _____ City _____ State _____ Zip _____

Home # _____ Cell #_____ Email _____

- **EMERGENCY CONTACT**

Name: _____ Relationship to Patient _____

Phone # _____

Can we discuss your medical history with this person if needed _____Yes _____ No

- **NAME OF PRIMARY CARE OR REFERRING PROVIDER**

Primary Care Physician _____ Referring Physician _____

- **INSURANCE**

Primary Ins _____ ID # _____ Subscriber Name_____
DOB_____

Secondary Ins _____ ID # _____ Subscriber Name_____
DOB_____

ASSIGNMENT AND RELEASE OF BENEFITS

I hereby assign all medical and/surgical benefits, to include Major Medical Benefits to which I am entitled, including Medicare, private insurance, and any other health plan to all our doctors. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges not paid by my insurance plan. I hereby authorize said assignee to release medical information to secure payment.

- I have read and understand the updated financial policy of Baystate Eye Care and understand that Baystate Eye Care reserves the right to change any/all fees at any time.

- **REFRACTION**

A refraction is the testing that is done to provide you with glasses. If you want a prescription for glasses we must do this test, even if you want the same prescription. If you do not want a prescription, the refraction may not be needed. A refraction is also needed for certain conditions, such as cataracts, even if you do not want a prescription.

A refraction is **NOT** covered by Medicare. Many other insurance companies also do **NOT** cover the refraction cost.

The purpose of this form is to help you make an informed choice about whether you want to have a refraction knowing the following information:

- **All Patients whose insurance does not cover a refraction, will be responsible to pay the $45.00 refraction fee on the day the refraction is performed.**
- If you wish to have a prescription for glasses, you **MUST** have a refraction**.**

Please choose **ONE** option and sign and date this form.

___ **YES**, I want to have a refraction. I understand that my insurance may not pay for it and **I am fully responsible for payment today.**

___ **NO**, I waive the choice of a refraction. I understand that I will **NOT** be given a prescription for new eyeglasses.

Co-Pay, Co-Insurance and Deductibles

If your insurance company sets a designated co-pay, **we are required to collect your co-pay at the time of service. If you are unable to pay at the time of service a $10 statement fee may be added to your account.**

Cancellations and Missed Appointments

Patients who no show an appointment or cancel with less than a 24-hour notice will be charged a **$25 cancellation fee***. If an appointment is missed a second time, without 24-hour notice**, a fee of $50 will be charged.** Any cancellation fees incurred must be paid prior to scheduling subsequent services.

***Please note: If you miss a *first-time* appointment at this practice and/or you have *been referred to us by another physician* and do not call to cancel/reschedule with at least a 24-hour notice, we will be unable to schedule another appointment and your referring physician will be notified.**

Insurance Referral Waiver

If your plan requires a referral and one is not on file, you will be responsible for the full cost of the visit, if a referral cannot be obtained.

MassHealth Financial Responsibility

We are not contracted providers of MassHealth. You will be financially responsible for any copays, deductibles, and co-insurance payments from your primary insurance, if MassHealth is secondary. Positive verification of your coverage cannot always be made at the time of service. **You will receive services with the understanding that in the event your coverage is not effective, you will be billed and held financially responsible for the services rendered.**

Patient Signature_____ Date_____

Parent/Guardian Signature_____ (if patient is a minor)

For Office Use Only:

Account # _____