OFFICE POLICY AND ASSIGNMENT/RELEASE FORM

Financial Responsibility

VISION EXAMINATION or OFFICE VISIT

Your exam payment is due the day you are examined. If you have insurance benefits, and that documentation is presented to us before your exam, you will be expected to pay your co-payment and any charges that your insurance company does not cover on your exam date.

GLASSES or CONTACTS

Your glasses or contacts will be ordered when ½ of your charges have been paid. The remaining balance is due when your glasses or contacts are dispensed. We expect your glasses or contacts to be picked up within two weeks of being notified by our staff.

RETURNED CHECKS:

There will be a $20.00 service charge on all returned checks.

Insurance Information

Our office accepts Medicare and most MEDICAID/TENNCARE payment for those services which these two agencies cover. Just like any private insurance plan you have had in the past, MEDICARE/TENNCARE may require you to pay a portion of your medical fees.

1. MEDICARE requires that you pay your MEDICARE DEDUCTIBLE out of pocket each year before they will pick up any charges that you acquire.
2. MEDICARE also requires that you pay 20 % of your bills after you have met your deductible. This is your MEDICARE CO-PAY. This portion may be covered by your secondary insurance if applicable.
3. TENNCARE will cover basic glasses in most cases under 21 years old.

When you are covered by MEDICARE and MEDICAID(QMB), MEDICARE by law is your primary insurance, meaning that we must first file with MEDICARE to see how much of your bill they will pay. After hearing from MEDICARE, we will file the remaining charges with MEDICAID. However, this does not mean that they will pay the entire remaining balance. Any balance remaining after both insurances have responded will be your responsibility.

When we do not participate in your insurance plan, the payment for services and materials is your responsibility. Payment should be made at the time of your visit.

I have read and understand the above paragraphs. I authorize my insurance carrier to pay benefits directly to Drs. Smith & Smith O.D.P.C. I am responsible for all NON-COVERED SERVICES. I also authorize the release of any information required to process my claim.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY: This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including reasonable attorney's fees and costs of collection in the event of default.

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Responsible Party Signature (MUST BE OVER 18) **Date**

___:_____ ___:_____ ___:_____ ___:_____ ___:_____ ___:_____

(initial: date)