**An Important Message to Our Patients**

Please be aware that due to the constant changes in insurance policies and regulations, it has become increasingly difficult to interpret each individual insurance policy. **We do try to contact your insurance to get an estimate for services as a courtesy, but per your insurance company, it is not a guarantee of payment. We cannot be held accountable for the amount quoted, as it is only an estimate provided to us by your insurance company.** It remains your responsibility to know and understand your individual policy, including your co-pays and deductibles. There is no standard policy for each insurance company; your policy was written per the options available to and offered by your employer.

**Please do not be upset with our office if your insurance does not cover all of our services**. Insurance policies typically have deductibles, co-pays, or co-insurances and may also have exclusions or waiting periods. Some may require that you get a referral from your primary care doctor in order to see a specialist. Our providers are considered ophthalmology specialists and your visit may require a referral and **specialist copay.**

Your individual insurance policy is between you and your insurance company and not between the insurance company and the doctor. ***It is your responsibility to let us know your INSURANCE policy requirements.***

**All co-pays and coinsurance payments are due at the time of service. If your policy has a deductible you will be responsible for all charges incurred at your visit(s) until the deductible has been met. Please check your policy if you are unsure about your deductible requirements. Deductibles are concurrent with your policy plan year; once a new plan year begins, a new deductible must be met. This applies to all services, including exams, procedures, diagnostic testing, surgery, frames/lenses, contact lens fitting.**

Certain procedures/testing may require pre-certification by your insurance company or may need to be performed at a special facility. **Lab fees for in office minor procedures are not included in your office visit** and will be billed out separately by the lab.

If you are unsure of any aspect of your coverage, please call the member service number on the back of your insurance card. The member services representative will be able to assist you with any questions you may have.

**ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE INFORMATION**

I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to **ST CLOUD EYE CENTER INC d/b/a EYE FLORIDA** for any covered services furnished by PROVIDERS EMPLOYED BY **ST CLOUD EYE CENTER INC.** I agree to pay to St. Cloud Eye Center INC, the deductible and/or coinsurance on my claim or any other charges not paid or denied by my insurance plans regardless of billings reasons.

I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents, Champus/TRICARE and its agents, or to any private insurance company any information needed to determine these benefits or the benefits payable for related services.

I further certify that the information provided by me is true, accurate and complete**. I ACKNOWLEGE THAT IT IS MY RESPONSIBILITY TO KNOW MY INSURANCE PLAN BENEFITS AND REQUIREMENTS. I understand and agree that I am responsible for the following expenses: any service my insurance plan deems "non-covered", all coinsurance and/or co-payment amounts, all deductibles, any amount that exceeds benefit limits under my insurance plan and any amount my insurance plan deems not covered because I was not insured on the date of service. IF I FAIL TO PROVIDE REFERRAL WITH AUTHORIZATION NUMBER FROM MY PRIMARY CARE PHYSICIAN AT TIME OF SERVICE I AGREE TO BE RESPONSIBLE FOR ALL FEES RELATED TO SERVICES RENDERED BY ST. CLOUD EYE CENTER INC.**

**I acknowledge having received 1) a copy of EYE FLORIDA INC’s Notice of Privacy Practices (NPP), and 2) EYE FLORIDA INC’s Office Policy including Financial Policy.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **PATIENT’S NAME PATIENT’S SIGNATURE / DATE**

If Responsible Party, Please Complete: NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Patient’s Inability to Sign: \_\_\_ MINOR \_\_\_\_ OTHER: PLEASE EXPLAIN \_\_\_\_\_\_\_