Thomas P. Reyburn, OD

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BILLING AND INSURANCE AUTHORIZATION

Insurance
We participate in many insurance plans. If you are not insured by a plan we do business with or do not have an up-to-date insurance card, payment in full is expected at each visit. When you provide us with current and complete information we bill primary and secondary insurance. If your insurance company does not pay your claim in 120 days, the balance will automatically be billed to you. Please contact your insurance company with any questions you may have regarding your coverage.

Payment
All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. You may pay by cash, check and credit/debit cards. You are responsible for paying any collection fees, attorney's fees, court fees etc. for the purpose of collection on delinquent accounts not paid within 120 days of service.

Non-Covered Services
Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. An example is Refraction, which is a test required to measure visual acuity and to prescribe lenses. Although an important part of your eye exam, it is excluded from Medicare and many medical insurance plans. We are required to charge your refraction fee separately from your exam. Screening retinal images and visual fields are also non-covered and may not be billed to your insurance or Medicare. Retinal imagery with diagnosis may be billed to your insurance or Medicare if there is a medical condition present. Payment for these services must be paid at the time of your visit.

Optical/Contacts
Eyewear orders must be paid in full at time of your order unless covered by vision insurance.
Contact lens fitting is not included in a routine eye exam; it is a separate procedure with an additional charge. Many insurance companies do not pay the fitting charge. A 50% deposit of the contact lens and fitting fee total is required before ordering lenses unless covered by a contracted insurance plan. Payment arrangements may be made in advance for eyewear and contact lens orders.

Patient Acknowledgment and Authorization
I authorize Ada Vision Center, P.C. to bill my insurance for services provided, and to make available any information needed to process my claim. I assign all insurance and/or Medicare benefits to Ada Vision Center, P.C. for services provided by them. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as this original.

Signature ____ Date _____________________

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

By signing below you attest that you have received, reviewed, and understood Ada Vision Center, P.C.'s privacy policy and the rights to privacy that you are afforded by federal legislation (HIPAA Privacy Act). The privacy policy outlines how your information is shared only for the purpose of performing service or collecting payment. These policies are subject to change or modification without notice.

Date __________________________

Print Name____

Signature ____

I authorize the release of any information including the diagnosis and records of any treatment or examinations rendered to me to:

____ Relationship to Patient: _____________________

____ Relationship to Patient: _____________________

□ Individual refused to sign ___________ (staff initials)