

# Low Country Eye Associates, P.C.

## Policy Statement for Patient Care Service

We appreciate you choosing Low Country Eye Associates, P.C. and welcome you as part of our family. If you are completing this as an established Patient, we thank you for returning and choosing us to care for your medical needs. We are dedicated to serving the diverse health needs of our community and commit to providing you with the very best care at the lowest cost possible. To achieve this, it is important for you to understand our financial summary policy and your responsibilities associated with payment of services rendered.

### Summary

As our Patient, you are responsible for the payment of all services rendered **at the time of your visit**. We file insurance claims as a courtesy to our patients, but the bill is your responsibility. It is very important, and your sole responsibility, to keep us informed of your mailing address, telephone number, employer, emergency contact and any other information that we need in order to provide you the highest level of service.

### Insured Patients

If you have insurance and we file on your behalf ***you are required to pay your co-payment and deductible to us at the time of your visit***. In addition, some plans have an annual deductible for which you are responsible. You may be required to pay up to the amount of your unmet deductible at the times of your visit depending upon your particular status with your insurance provider. In the event that there remains a balance due after your insurance carrier has paid its portion, we will bill you and expect payment within 10 days from the receipt of this bill.

### Uninsured Patients

You are considered a Self-Pay Patient if an insurance provider, Medicare or Medicaid does not cover you. Payment is required in full at the time services are rendered unless other arrangements are made.

### What If You Cannot Pay?

We understand and want to help you to ensure that you receive proper medical care. If you feel that you cannot pay at the time of your visit, please let our Patient Advocate know in advance so that we may assist you with the completion of an adjusted fee application.

### Application Fees

There are many insurances where you may require certain forms to be completed. In those cases whereby the form is for referral purpose, there will never be a charge. However in those cases where forms are necessary for services outside the scope of your direct care, we reserve the right to impose a processing fee. In those cases, you will be informed in advance.

### Authorization For The Release Of Medical Information

Your signature authorizes Low Country Eye Associates, P.C. to release medical information pertinent to the payment of medical expenses incurred by you to the insurance carriers named or its intermediaries, carriers, agents or billing agents. You permit a copy of this authorization to be used in place of the original request for payment of medical insurance benefits whether to yourself or to the party who accepts assignment.

In addition, your signature authorizes Low Country Eye Associates, P.C. to release medical records to those Specialists for whom you have been referred to for extended medical care. This will only occur when it is medically necessary in measuring your overall health care needs.

(Over Please)

## Assignment Of Insurance Benefits

Your signature below also hereby assigns your rights under the named policy of insurance, indicated on your Patient Information Profile, to Low Country Eye Associates, P.C., and it is not limited to major medical insurance, hospital benefits, sick benefits or injury benefits. In the event a third party is deemed liable for your medical condition, you assign your rights under an insurer, such as auto insurance, workman's compensation insurance, medical, hospital or disability payments.

## Consent For Medical Care

You authorize Low Country Eye Associates, P.C. to render medical treatment as they deem appropriate under the direction of your primary care physician/provider and/or such associates, partners or designees as may be selected by him/her to perform such treatment. You recognize that during the course of treatment conditions may arise that necessitate additional procedures or services and you further authorize and request that your physician/provider and/or his/her associates, partners, assistants or designee perform such procedures or services, as are in his/her best professional judgment, necessary and desirable.

For the purpose of advancing medical knowledge, you consent to the admittance of medical or other health care profession students and observers in accordance with the ordinary practices of this medical facility.

No guarantees or assurances have been made or given by anyone as to the results that may be obtained by any treatment or procedures rendered you.

## Appointments

We serve our Patients on an appointment basis and require each Patient to keep their appointment. However, we understand that there are times when an appointment cannot be kept. In those times we ask that you call 24 hours in advance to cancel your appointment so another Patient may be seen.

## Account Status

Please keep you account current. Communication is the key and our Patient Advocates are here to assist you.

Our team of professionals is dedicated to working with you, our Valued Patient, in every manner possible. Please do not hesitate to let us know how we may be of help and we will do everything possible to assist you. Thank you for visiting us today, and we thank you in advance for your signature below acknowledging your receipt of this policy and the acceptance of your responsibility.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Parent/Guardian  
(if under 18 years of age)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

(Low Country Eyecare Employee)