Low Country Eye Care

Policy Statement for Patient Care Service

We appreciate you choosing Low Country Eye Care. If you are completing this as an established patient, we thank you for returning and choosing us to care for your medical and vision needs. We are dedicated to serving the diverse health needs of our community and committed to providing you with the very best care. 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 with 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 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 the bill. You are considered a Self-Pay Patient if an insurance provider, does not cover you. Payment is required in full at the time services are rendered unless other arrangements are made.

If your exam reveals a medical condition or disease related to your eye that requires specific counseling, documentation, follow-up care, regular monitoring or referral to a surgeon, you have a complaint related to a non-refractive nature, or if the exam is related to a pre-existing condition such as cataracts, glaucoma, diabetes, dry eyes, etc., then your visit is NOT COVERED by your Vision Plan. For instance, if you come in because you are having difficulty seeing with your current glasses, but it is found that your reduced visual acuity is due to developing cataracts, then your exam would have to be billed to your medical insurance.

Additionally, if we do file the exam with your medical insurance, you can still use your Vision Plan benefits towards the purchase of glasses or contact lenses based on your plans allowances. At times it can seem like a complicated process, but these are the rules set by your insurance company. We would be happy to answer any questions that you may have about your insurance coverage.

Authorization For The Release Of Medical Information

Your signature authorizes Low Country Eye Care 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.

ln addition, your signature authorizes Low Country Eye Care to release medical records to those Specialists for who you have been referred to for extended medical care. This will only occur when it is medically necessary in managing your overall health care needs.

We will not under any circumstances sell your information to a third party for marketing or fund raising purposes without your written consent.

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 Care, 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.

_____	_____	_____
Authorization for release of Medical Information	Relationship	Telephone Number

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 in advance to cancel your appointment so another patient may be seen. Failure to cancel or reschedule a scheduled appointment, may result in a fee.

Account Status

Please keep your account current. Communication is the key and our Patient Advocates are here 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.

HIPAA

Your signature below indicates that you have received and reviewed a copy of the revised Health Insurance Portability and Accountability Act (HIPPA) notice. We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy policies will be described in a revised Notice that will be posted in our facility. Copies of this Notice are available upon request in our reception area and on our website.

Notice Revised and Effective January 29, 2015.

_____	_____
Patient Name (Print)	Date
_____	_____
Signature of Patient or Parent/Guardian	Relationship to Patient