



FINANCIAL POLICY

LEVIN EYECARE is dedicated to providing quality patient care and we are also aware that financial concerns are part of our welfare.

Before/during your visit, LEVIN EYECARE is required to verify your member eligibility with your insurance company. In addition, for your protection and in accordance with federal regulations, LEVIN EYECARE is required to verify your identity (valid driver’s license or other form of acceptable photo identification). Your failure to provide an acceptable form of photo identification may cause denial of services. Please inform the front desk staff if you have any concerns regarding your insurance benefits or if you are self-pay (you do not have insurance coverage). If you are self-pay, and unable to satisfy your financial obligations to LEVIN EYECARE, you may want to contact your local health department to see if you are eligible for Medical Assistance.

We recommend that patients contact their insurance carrier for specific questions related to you Explanation of Benefits.

NOTE: Please read the following carefully, initial where indicated and sign below. We understand that these may not all apply to you, we want you to understand what our policies are, **please initial each area.**

CO-PAYMENTS & REFRACTION FEES

_____ Co-payments and refraction fees are due at the time services are rendered per your contract with your insurance company. Payment can be made by cash, check, MasterCard, Visa, American Express or Discover. We WILL NOT bill for this.

REFERRALS

_____ Referrals must be presented at the time services are rendered, if applicable. If you need to have one faxed to us, our office fax number is 443-940-1214, please give this number to you primary care physician. Without a referral, your appointment will be rescheduled, it is the patient’s responsibility to obtain the referral; the office staff will not obtain referrals for patients.

FINANCIAL RESPONSIBILITY

_____ Patients are responsible for all co-payments, deductibles, refraction fees, and charges not covered by their health insurance. Without valid health insurance, full payment is expected at the time services are rendered.

NO SHOW/SAME DAY CANCELLATION POLICY

_____ A \$25 missed appointment fee will be charged for any missed appointment where a patient does not notify our office to cancel at least 24 hours prior to their appointment. The fee will be the responsibility of the patient to pay and will not be billed to their insurance company. This same policy applies to any procedure performed at the Northern Baltimore Surgical Center facility. A \$100.00 missed surgery appointment fee will be charged for any surgical procedure canceled within 24 hours of a scheduled procedure.

ACCOUNT BALANCES

_____ Our office provides you with monthly statements of all activity including charges, payments and contractual adjustments. Failure to pay outstanding balances that are your responsibility may result in the practice forwarding your account to a collection agency or Collection Attorney of our choice and may result in additional fees, including attorney’s fees of 30%. If your payment is returned due to insufficient funds or stopped payment, you will be charged the return check fee allowed by Maryland State Law.

THE FOLLOWING APPLIES TO PATIENTS WITH MEDICARE ONLY OR A MEDICARE ADVANTAGE PLAN ONLY!

_____ I hereby authorize and request my insurance company to make payment directly to LEVIN EYECARE and any wholly owned subsidiaries of any benefits that may be due for covered services and supplies rendered to me by TOTAL VISION associates.

Date: _____

Signature of Patient (or legal Guardian): _____

Printed Name of Patient: _____

Statement of Privacy Policy Posting

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can be used and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by LEVIN EYECARE of their Notice of Privacy Practice containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Practices prior to signing the consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that LEVIN EYECARE restrict how my private information is used or disclosed to carry our treatment, payment, or health care operation. I also understand that LEVIN EYECARE is not required to agree to my requested restrictions, but if LEVIN EYECARE does agree then the organization is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that LEVIN EYECARE has taken action relying on this consent.

PLEASE INDICATE THE PREFERRED MEANS OF CONTACTING OR LEAVING A MESSAGE FOR YOU:

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Other Number: _____

OTHERS WHO YOU GIVE PERMISSION TO HAVE ACCESS TO YOUR HEALTH INFORMATION (other than your physicians)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

**** CHECK HERE _____ IF YOU PREFER RESTRICTION FROM ALL PARTIES**

PATIENT NAME: _____

PATIENT SIGNATURE: _____ DATE: _____/_____/20____

WITNESS SIGNATURE: _____ DATE: _____/_____/20____

