DES PERES EYE CENTER FINANCIAL POLICY

Updated January 1, 2020

Our office participates with most major insurance plans. We provide **MEDICAL, SURGICAL and VISION** ophthalmologic care to our patients.

If you have a managed care plan that requires a referral to see a specialist, you must obtain a referral in order for your visit in our office to be covered under your medical insurance. If you do not have the valid referral and still wish to be seen, you will be asked to pay for the visit prior to your examination.

A refractive examination is not a covered service by most medical insurance companies, including Medicare. When you receive a refraction, you will be charged $45 which is payable at the time of visit. This also applies to the Contact Lens Check that is charged yearly to contact lens wearers.

BILLING**As Medical Doctors, we will bill your office visit to your Medical Insurance unless specified by the patient as ROUTINE ONLY with authorized Vision Insurance to apply.**

It is the patient's/parent's/guardian's responsibility to:

- Provide our office with accurate insurance information, including co-pays, co-insurance and deductibles.
- **You will be responsible for your office visit and any charges resulting from that visit if your insurance is inactive on your date of service or Des Peres Eye Center is out of network for your insurance plan.**
- Bring any required PCP referrals, if no referral is on file you will be responsible for the office visit charge.
- Provide our office with current information including address, phone number and employer.
- In accordance with your insurance contract, you must be prepared to pay your co-pay at each visit. If you do not make your co-payment at the time of the visit, you will be charged an additional **$5 billing fee**. We accept cash, checks and all major credit cards for services.

We appreciate prompt payment in full for any outstanding balance. If your account is turned over to our collection agency, you agree to pay any fees imposed by the collection agency in order to collect the overdue amount. Any check payments that do not clear the bank will be subjected to a **$25.00** returned check fee.

There will be a **$35.00** charge if you fail to show for any scheduled appointment. Any patient, who does not show up for a scheduled surgery, will be charged a cancellation fee of **$250.00**. Legitimate emergencies will be taken into consideration.

I agree to permit Des Peres Eye Center and their business associates to contact me, and all other responsible parties on my account, on our cell phone or other mobile devices concerning any and all aspects of my account.

I have read and understand the Des Peres Eye Center financial policy updated 01/01/2020.

____ ______________

Signature of patient/guardian/parent Date

It is Des Peres Eye Center's ongoing mission to give our patients the finest care possible. We apologize for any inconvenience these changes cause. If you have questions regarding the new fee structure, please call us.

Sincerely, Drs. David Brigham, Eric Chiu and Kirk Morey

DES PERES EYE CENTER

ACKNOWLEDGMENT OF PRIVACY PRACTICES AND HIPAA DISCLOSURE AUTHORIZATION

Receipt of Notice of Privacy Practices:

_______ *(Initial)* I acknowledge I have received or I have been provided the opportunity to receive a copy of Des Peres Eye Center's (DEC) Notice of Privacy Practices that explains when, where and why my protected health information may be used or shared by DEC.

HIPAA Disclosure Authorization(s):

_______ *(Initial)* I authorize DEC to leave a message on my voicemail &/or other electronic means at the following number(s):
____

_______ *(Initial)* I authorize DEC to provide the following person(s) with my protected health information:

Print Name:_________________________ Relationship to Patient__________

Print Name:_________________________ Relationship to Patient__________

Print Name:_________________________ Relationship to Patient__________

_______ *(Initial)* I DO NOT authorize DEC to disclose my protected health information to anyone other than myself, except as permitted by HIPAA as described in DEC's Notice of Privacy Practices.

I understand the HIPAA Disclosure Authorization(s) above may be revoked in writing at any time; however, the revocation will not affect disclosures of information previously authorized.

INFORMED CONSENT FOR TELEMEDICINE SERVICES

Telemedicine involves the use of electronic communications (phone, computer, etc) to enable health care providers to share medical information with a patient.

<u>EXPECTED BENEFITS</u>:

- Improved access to medical care by enabling a patient to remain in his/her location while the healthcare provider provides medical information at a distant site.
- Limiting the spread of COVID-19 and other communicable diseases.
- Ability to obtain consultation from a distant medical specialist without traveling.
- Allow medial evaluation and management of patients who are unable to travel.

<u>POSSIBLE RISKS:</u> As with any medical procedure, there are risks associated with the use of telemedicine. These risks include, but not limited to:

- Information transmitted may not be sufficient to allow for appropriate medical decision making by the health care provider. For instance, certain parameters of the eye exam cannot be tested remotely, such as eye pressure. In addition, there could be poor resolution of images. This could cause delay in evaluation and treatment.
- Security protocols could fail, causing a breach of privacy of personal medical information.
- A lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other medical errors.

<u>CONSENT:</u>

- You have read this informed consent form, or someone has read it to you.
- You understand the information in the informed consent and all of your questions have been answered.
- You have been offered a copy of this informed consent form.

NAME OF PATIENT ___________________ DATE OF BIRTH__________________

Signature of Patient (OR person authorized to sign for patient): ___________________
If Authorized signer, relationship to patient: ________________________

DATE _________________________