



PLEASE READ THE POLICIES CAREFULLY. WE ASK THAT YOU SIGN THE SECOND PAGE
ACKNOWLEDGING YOUR UNDERSTANDING.

Office Policy on Managed Care Insurers and Vision Insurance

In order to accommodate the needs and requests of our patients, we participate in numerous managed care insurance programs and most all vision carriers. While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep track of all the individual requirements of the plans. Each one has different stipulations regarding how often services may be rendered. Even with the same insurance company, the plans differ, depending upon the type of contract your employer has negotiated.

Unfortunately, if you do not inform us of any special requirements in your contract, and we subsequently order services such as testing and/or materials that are not covered, we will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility. In the event that services are provided and your coverage is not in effect on the day of service, the claim submitted will be denied by your carrier and will become your responsibility.

I request that payment of authorized insurance benefits be made to DePoe Eye Center for any services furnished to me by the doctors of DePoe Eye Center. With your cooperation and help, you should be able to receive all benefits offered to you. We will be able to concentrate on caring for your medical and vision needs.

GEORGIA TECH STUDENTS ONLY

By signing this document, I give DePoe Eye Center the authority to give my name, student ID# and date of my health evaluation to Georgia Tech for reporting purposes only. No further information will be shared.

VISION INSURANCE vs. MEDICAL INSURANCE

We often have patients that have both vision and medical insurance. They are different in terms of the services they cover and it's important for our patients to understand those differences. Vision coverage is mainly designed to determine a prescription for glasses or contact lenses. It is not equipped to deal with complex medical conditions, diagnosis and/or treatment plans. When a medical diagnosis or condition is present (such as diabetes, glaucoma, dry eye, cataracts, red/pink eye) it is necessary to file the visit with your major medical carrier and the co-payments/deductibles for that insurance will apply as well as any non-covered service. **Our office does not make these rules and they are defined by the insurance carriers themselves.** There is no way to know prior to the examination which type of insurance our office will be able to file for you. We make every effort to be on every major carrier for your convenience and we will file those claims for you. In the event that we do not take your major medical medical/vision insurance, we will provide you with an itemized statement/receipt so that you may file with your carrier for reimbursement. If you have questions, please let us know.

Consent for Treatment

I/We hereby authorize DePoe Eye Center to administer diagnostic and medical procedures and treatments as may be necessary for proper health care.

Acknowledgement of Notice of Privacy Practices (NPP)

I, _____, have received/read a copy of this office's Notice of Privacy Practices (NPP).
Copies will be given at the patient's request.

I give DePoe Eye Center permission to speak with the following (family member / parent):

_____, _____
regarding my account billing and/or treatment needs.

I authorize DePoe Eye Center to correspond with me through the contact information provided to this office via text, voice, and email for reminders, test results, prescription instructions. Billing/insurance, and/or collection purposes.



Acknowledgement of Financial Policy

The total professional fee is due at the time services are rendered. Any materials (glasses or contact) fees are due at ordering. No materials will be ordered until all fees have been paid. We gladly accept Visa, MasterCard, Discover, American Express, cash and many flexible spending cards. **We are no longer able to accept checks.** We now offer Care Credit as a method of payment with 0% financing for balances up to 12 months.

We will bill for any balances over 30 (thirty) days old. Any account over 60 days old will be subject to a late fee. Full collection proceedings will be utilized for any account aging 90 days, unless prior arrangements have been made.

All No Show appointments will be charged \$35.00, if 24 hour notice is not given.

Insurance Information (Major Medical) PRIMARY

Insurance Name		Group Name	
ID#		Group #	
Address			
Subscriber Name		DOB	

Insurance Information (Major Medical) SECONDARY (if applicable)

Insurance Name		Group Name	
ID#		Group #	
Address			
Subscriber Name		DOB	

Insurance Information: VISION

Insurance Name		Group Name	
ID#		Group #	
Address			
Subscriber Name		DOB	

Responsible Account Holder (Parent or Guardian for patient's under age 18)

Name		Salutation	
Relationship		DOB:	
Address			
Home #		Cell #	
Work #		Email:	

Emergency Contact

First Name	Last Name	Relation	Home #	Cell #	Work #	Ext

Please sign below that you acknowledge and understand all the policies above:

Patient Signature: _____ **Date:** _____