Whitson Vision Patient Information and Policy

1. **Patient Information:** A fully completed, current patient information registration will be on file in the patient chart during all times the patient is considered an active patient. Patient registration will be updated annually by the patient. The social security number (and Driver's License for new patients) is required as is the signature of the responsible party prior to any medical services.

2. **Insurance Claims:** Whitson Vision will file a claim upon patient's proof of insurance (i.e. insurance card indicating coverage, identification number and group number). In the event the patient is unable to provide documentation, payment is due at the time of service. Upon check out, the patient may request an itemized receipt to submit to their insurance company.

3. **Secondary Insurance:** Secondary insurance will be filed for patients upon submission of proof of secondary insurance. However, if payment is not received in our office within 45 days after filing, the responsibility will be transferred to the patient. Payment will be due from the patient upon receipt of the patient statement.

4. **Patient Financial Responsibility:** It is the sole responsibility of the patient to ensure that Whitson Vision is in their insurance network. This information may be obtained from your insurance company. If Whitson Vision is not a provider, payment is expected in full at the time of service. All co-payments, deductibles, co-insurance and non-covered services are due at the time of service. **Also,** I understand that Medicare, Medicaid and other private insurance carriers may not cover **REFRACTIONS**, and other procedures that they deem medically unnecessary. The **refraction** test will tell your doctor what prescription lens you should use in order to have 20/20 vision or as close to 20/20 vision as circumstances permit. Expenses for all refractive procedures, whether performed by an Ophthalmologist or an Optometrist and without regard to the reason for the performance of the refraction, are excluded from coverage. The refractive procedure fee is **$60.00.**

5. **Minors/Dependents:** Children under the age of 18 will require the signature of parent or guardian on the registration form. A patient under the age of 18 must be accompanied by a parent or guardian to receive services.

6. **Method of Payment:** Acceptable methods of payments are: cash, check, MasterCard, Visa, Discover and American Express. Additionally, we offer several no interest payment plans through Care Credit.

7. **Past Due Accounts:** Payments of patient statements are due upon receipt. Whitson Vision will send out one additional reminder of the balance owed. Non-compliance will result in preparation of the account to collections which may result in court action, adverse credit rating reporting and possible discharge from the practice. In the event the account is turned over to collections, the person financially responsible for the account will be responsible for all collection costs, including reasonable attorney fees and court costs.

8. **Finance charges/ Convenience Fee:** I understand that if I am treated as a patient at Whitson Vision that there may be a finance charge on all accounts over 30 days or more past due at a rate of .67% per month, an annual rate of 8%. I understand that a convenience fee of $25.00 will be added to my account for all phone-in credit card payments in excess of $1000.

9. **Account Consultation:** Physicians are not prepared to discuss financial issues. If you need further assistance a representative from our billing department will be consulted.

10. **Self Referral Disclosure:** HB1306 requires the referring physician to disclose any financial interest in a health care facility to all patients being referred to the facility. The Medical Doctors (MD) at Whitson Vision have a financial interest in Central Indiana Surgery Center (CISC), Eagle Highlands Surgery Center and Naab Road Surgery Center. You may elect to be referred to another health care facility.

11. **Release of Information:** In order to submit a claim for payment to us for services covered under your vision or medical insurance policy, we must have your authorization to release medical information to your insurance carrier. Your signature below authorizes the release of this information.

PLEASE CONTINUE TO NEXT PAGE TO SIGN

12. **Miscellaneous Form Completion:** Whitson Vision will generally complete any form that is requested by your primary care physician or you, (i.e. disability, adoption, etc.). A fee in the range of $15.00 – $30.00 will be applied. The charge will be based on the complexity of the forms and the amount of time needed for completion. The charge is considered the patient's responsibility, and payment is required upon completion of the paperwork.

13. **Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191:** We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights. This information, in detail, is available at the front check in counter at all of our locations. Please take the time to read and understand you rights under HIPAA. Your signature below indicated that you have read and understood this information.

14. **Contact by Cell Phone or Email:** I agree, in order for Whitson Vision to service our account or to collect any amounts you may owe, we may contact you by telephone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact by sending text messages or e-mails, using any e-mail address you provided to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device as applicable. I have read this disclosure and agree that Whitson Vision may contact me/us as described above.

15. **Cancellation/No Show Policy**
    When you do not show for a scheduled appointment, it creates an unused appointment that could have been used for another patient. It is very important that you call 24 hours in advance to cancel your appointment. If for any reason you need to cancel an appointment, please notify our office as soon as possible. **In the event of cancellation less than 24 hours in advance or a no-show occurrence: For an office visit there will be a $45.00 charge to your account; For a procedure appointment, such as a YAG, PI, SLT Laser or an Injection, there will be a $75 charge to your account.** After three consecutive no show occurrences, the practice may elect to terminate our relationship with you.

16. **Disclosure of Protected Health Information:** I authorize my healthcare provider to disclose my Protected Health Information to the following individual:

To Whom Disclosed (Please list a family member):

Name: ____

Telephone: ____

Relationship: ____

I have read and understand these policies:

Print Patient Name: ____

Signature and Date: ____