INSURANCE COVERAGE DISCLAIMER/CLINIC FINANCIAL POLICY

Due to the recent and unpredictable changes within the insurance industry, effective immediately Lakeside Eye Associates is requesting all patients to verify and be familiar with their insurance benefits prior to being seen in our office. As a courtesy, our staff will continue to verify and bill your insurance, but we cannot guarantee coverage or that the information we have received from your carrier and conveyed to you is accurate or complete. Please read and sign that you have received and understand the following:
I understand that Lakeside Eye Associates will bill most insurance carriers and that all co-pay and deductible amounts are expected to be paid at the time of my appointment unless other arrangements have been made in advance. Should I have a balance for any reason after my insurance has processed the bill, a statement will be sent to me. It will be my financial responsibility to pay this balance due.

I understand that if my insurance company requires a referral or pre authorization, it is my responsibility to obtain this referral from my medical doctor prior to my appointment. I accept the full responsibility of keeping track of the number of visits allowed and the number of visits used. It is my responsibility to track the expiration date of the referral or preauthorization.

I have read and understand that if my insurance does not pay in full for the services provided by the health care providers in this clinic, I assume liability for the allowed unpaid portion, within the confines of my policy.

I authorize the release of any medical records that might be necessary to facilitate payment of services and authorize the insurance company to make payments directly to the clinic and/or provider. It is understood that the providers within this office have access to each other's records without further authorization, and that my records may be released to other physicians directly involved in my care.

I also understand that it is my responsibility to fully understand my insurance benefits and that the benefits quoted to me by this office are based on information provided to Lakeside Eye Associates by my insurance carrier. I understand that Lakeside Eye Associates must abide by the rules governing my insurance coverage, but ultimately coverage is based upon my contractual agreement with my insurance carrier. *All services are subject to medical necessity.* I further acknowledge that if it is requested of me, that I agree to assist my provider in obtaining the proper documentation and/or referrals from my primary medical provider to substantiate the medical necessity of my treatment in this office.

Medicare patients: I understand that ROUTINE examinations, including Refractions, performed in this office are not covered by Medicare and most secondary insurances.

I understand that keeping appointments or canceling them with adequate notice prior to my appointment time is my responsibility. Otherwise, I may be charged a $25.00 fee for missed appointments ("no shows").

Signed _____ *Printed Name of Patient or Guardian*_____

*Date*_____