Prado
Vision & Lasik Center

Our Financial Policy

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance. For your convenience, we accept cash, check, Visa, MasterCard, Discover and debit cards.

2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. It is the patient's responsibility to know his or her insurance benefits. As a courtesy to you, we will file your insurance claim if you assign the benefits to the doctor - in other words, if you agree to have your insurance company pay the doctor directly. It is your responsibility to contact your insurance company to resolve any nonpayment issues. If your insurance company does not pay the practice within ninety (90) days or denies payment, payment will become your responsibility. If we later receive a check from your insurer, we will refund any overpayment to you.

3. For HMO, PPO, or other managed care networks in which we participate, our policy is that all co-payments, deductibles and other non-covered health care services and supplies be paid at the time of service.

4. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. There will be a $10.00 statement fee added to your outstanding balance for all statements mailed excluding the first statement.

5. There will be a $25.00 returned check fee on all returned checks.

6. If your account remains unpaid, you will be responsible for all attorney, collection fees and charges incurred to collect this debt.

7. Please be aware that performing a **refraction** (the testing of vision where a series of lenses are presented to the patient to determine which provides the sharpest, clearest vision) is not a covered benefit under many insurance plans, including **Medicare. Our refraction fee is $40.00 and is due at time of service.** Additionally, we do no bill any insurance carriers, other than those with which we are contracted, for contact lens fits, supplies or glasses. Payment is due at time of service.

Cancellations

We know that there will be times when you will not be able to keep the appointments that you scheduled. We only ask that if this occurs you call us at least 24 hours in advance so that we can provide your appointment slot to another patient. **If you fail to notify us and fail to keep your appointment, you will be charged a "no show" fee of $25.00.**

Referral Authorization

Please note that is important that you bring your insurance card(s) and any Referral Authorization information required by your insurance company. If you are not sure whether a Referral Authorization is required, contact your insurance company prior to your visit to our office. Patients who do not obtain the proper Referral Authorization prior to the office visit will be required to reschedule their appointment or pay in full for all services rendered at the time of service.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature of Patient (or responsible party, if minor) Date

Please Print the Name of the Patient

INSURANCE AUTHORIZATION

I authorize the release of all medical and insurance related information to the Health Care Financing Administration, its agents, and/or any other insurance carriers, as needed to determine benefits or process claims for the physicians of **PRADO VISION AND LASIK CENTER.**

I permit a copy of this authorization to be used, as needed, in place of the original, and I request payment of Medicare and/or other medical insurance benefits be made to **PRADO VISION AND LASIK CENTER**, on my behalf for services rendered.

I am responsible for all financial obligations of health services for the above patient.

Signature of Patient or Responsible Party Date

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Póliza Financiera

Estamos dedicados a proporcionar el mejor cuidado medico. Necesitamos que nuestros pacientes entiendan el plan de cobro de esta institución.

1. Su obligacion de pago sera cobrada el dia de su cita, a no ser que se haya realizado un arreglo previo. Para su conveniencia aceptamos tarjetas de credito Visa, MasterCard, Discover y tarjetas de cargo a su cuenta bancaria, cheques personales y dinero en efectivo.

2. Por favor tenga presente que su poliza de seguro medico es un contrato entre usted y dicha compañia de seguro. Es su responsabilidad conocer su plan y sus beneficios. Los cargos ocurridos se enviaran a su compañia de seguro medico. Si su compañia de seguro medico no envia el pago de servicios facturados en 90 (noventa) dias tal cuenta se convierte en su responsabilidad. Le re-envolsaremos cualquier cantidad monetaria si recibimos pago en exceso de su compañia de seguro.

3. Para aquellos que estan asociados a un plan medico HMO, PPO u otro su co-pago y deducible seran su responsabilidad el dia de su cita.

4. No todas las compañias de seguro cubren todos los cargos incurridos por su membrecia. Usted sera responsable por todos los cargos no cubiertos por dicha compañia. El pago debe ser enviado a nuestra oficina cuando usted lo ha recibido. Un costo adicional de $10.00 sera sumado a su cuenta si usted requiere que le enviemos por correo otra cuenta de los cargos debidos.

5. Un cargo adicional de $25.00 sera cargado a su cuenta por cada cheque devuelto por su banco.

6. Usted sera responsable por todos los cargos incurridos por un abogado o compañia de cobros para saldar su cuenta.

7. Por favor entienda que una refracción de la vista, (la medida de su vision para la receta de sus lentes) no es un beneficio que la mayoria de compañias de seguro, incluyendo Medicae, extienden a su membrecia. El costo de medir la vista es $40.00 y esta cantidad se cobra el dia de su cita. No enviamos cargos de lentes de contactos o espejuelos a compañias de seguros a no ser que existan contratos de servicios opticos con la compañia de seguros. Estos cargos seran cobrados el dia de su cita.

Cancelaciones

Nosotros entendemos que hay veces que no va poder acudir a la cita con su medico. Se requiere por lo menos 24 horas de aviso si no puede acudir a su cita. Esto nos proporciona poder ofrecer esta cita a otro paciente. **Si used no avisa y no se presenta a su cita sera cargado $25.00 adicionales.**

Referidos

Es importante que usted presente tarjetas de identificacion de su seguro medico, tambien referidos y autorizacion de su seguro el dia de su cita. Si used no sabe si necesita una autorizacion de su seguro medico, por favor comuniquese con su seguro antes de su cita para obtener esta informacion.

Yo e leido y entiendo el plan de cobro de esta institucion. Yo acordo cumplir con estos terminos. Tambien entiendo que estos terminos pueden ser cambiados por esta institucion en el futuro.

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Firma del Paciente (o agente responsable) Fecha

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Nombre del Paciente

AUTORIZACION DE SEGURO

Yo autorizo que informacion de mi condicion medica e informacion sobre mi seguro se puede transmitir al Health Care Financing Administration, sus agentes, u otras agencias de seguros para determinar los beneficios y para recibir pagos a **PRADO VISION Y LASIK CENTER.**

Yo permito que una copia de esta autorizacion pueda ser usada en vez de la original. Tambien apruebo que los pagos de Medicare y otros seguros sean pagos directamente a **PRADO VISION Y LASIK CENTER**.

Yo sere responsable por todas las obligaciones financieras del paciente.

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Firma del Paciente o Agente Responsable Fecha