STRASBURG FAMILY EYECARE, LLC
Patient Information &Financial Policy

Thank you for choosing Strasburg Family Eyecare, LLC as your eye care provider. It is our goal to meet our patients' needs and address all concerns effectively. An area of primary concern for all patients is the financial policies of the practice, especially those pertaining to insurance billing and payment requirements.

PAYMENT: **50%** of the entire bill for Eyecare Products is expected when order is placed if you are not using insurance. **100%** of all Exams, deductibles, coinsurances and co-payments for exams and products is due before orders are placed. Patients who have an insurance carrier with whom the practice has a valid contract will be responsible for all fees as outlined in the patient's contract agreement.

REFERALLS ARE THE PATIENT'S RESPONSIBILTY!!! If you do not have your referral at the time of your visit, you will be financially responsible for the charges at that visit. CLAIMS ARE FILED ONLY FOR INSURANCE CARRIERS WITH *WHOM WE HAVE A CONTRACT AGREEMENT.*

LENSES: ***ALL LENSES ARE NON-REFUNDABLE.***

FRAMES: 30 Days from order placed return policy less a restocking Fee of no less than $10. Warranty for Frames is administered by Frame Vendor and subject to their breakage policies.

RETURNED CHECKS will result in a $35.00 service charge.

STATEMENT & BILLING CORRESPONDENCE: are sent to update the patient as to the status of the account and whether your insurance has fulfilled their obligation to you to pay claims in a timely manner.

DELINQUENT ACCOUNTS are placed for collection 90 days from the date the service was provided. Patients having financial difficulties are encouraged to talk with our financial counselor or office manager before the account becomes delinquent and a $50 late fee is applied.

INSURANCE ONLY: I, the undersigned, certify that I or my dependents have insurance coverage, and assign directly to Dr. Lauver/Dr. Moyer/Strasburg Family Eyecare, LLC, all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature of Responsible Party ***Date***

INSURANCE & DEMOGRAPHICS INFORMATION

Print Patient Name: _____**DOB**: _____
Marital Status: Married Divorced Widowed Single **Spouse Name:** _____
Employment: Full-time Part-Time Unemployed Retired Student **Social Security #**_____
Email:_____ **Phone #:**_____
Address:_____**City**: _____
State:_____**Zip**:_____ **Phone**:_____
Release of records to: _____ **Relationship**:_____
Primary Care Physician: _____ **Phone**: _____
Specialty Physician: _____ **Phone**: _____
Physical/Occupational/Speech Therapist: _____ **Phone**: _____
School (if patient is under 25): _____ **Phone**: _____
Workers Comp Case worker: _____ **Phone**: _____

HIPAA: A copy of this offices' HIPAA policy is available upon request. I understand that my records are kept confidential by this office, unless my signature is obtained for release of my or my dependents records.

Initials: _____

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Guarantor/Member Information:

Primary Medical Insurance Information:

Guarantor/Member Name: _____
Date of Birth: _____ Social Security #:_____
Relationship to Patient: _____
Address: _____ City: _____ State: _____Zip: _____ Phone:_____
Insurance Co.: _____
Insurance ID#: _____ Group ID#: _____
Vision Insurance: _____ ID#_____

Secondary Medical Insurance Information:

Guarantor/Member Information:

Guarantor/Member Name: _____
Date of Birth: _____ Social Security #:_____
Relationship to Patient: _____
Address: _____ City: _____ State: _____Zip: ____
Phone:_____
Insurance Co.: _____
Insurance ID#: _____ Group ID#: _____

I have read the Financial Policy of Strasburg Family Eyecare, LLC and understand and agree to adhere to the policies as outlined. I understand that I am responsible to pay my financial obligation in full by the date specified by the office. If for some reason I do not pay the balance in full, I will be held accountable for any and all late fees, collection fees, interest, or finance charges, etc. that may accrue.

_____

Signature of Responsible party/Guarantor **Date**

MEDICARE WITH SUPPLIMENT PATIENTS ONLY; *PLEASE READ AND SIGN BELOW*:
I request that payment of authorized Medigap benefits be made either to me or on my behalf to the provider of service and (or) supplier for any services furnished to me by that the provider of service and (or) supplier. I authorize any holder of Medicare information about me to release to (Name of Medigap Insurer) any information needed to determine these benefits payable for related services.

_____ _____

Signature of Medicare Patient **Date**

Emergency Contact information:

Name:_____
Relationship: _____Phone number: _____

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Financial Policy: Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with a Scheduling Coordinator at the appointment.

1. As the Patient or Guarantor, you are responsible for all charges incurred.
2. If you do not have vision insurance, payment in full is expected at time of service.
3. Although **we estimate** your insurance benefits, we are NOT responsible for their accuracy.
4. We expect payment for your estimated portion of the balance at the time of the exam.
5. We accept assignment of benefits with some vision plans. We bill those plans and require you to pay the co-pay or deductible at the time of service.
6. If your vision plan does not assign benefits to our practice, you will be required to pay the balance in full at the time of the visit.
7. Past due accounts are subject to collection proceeding. All fee's, including but not limited to collection fees are your responsibility in addition to the balance due to our office.

Your signature below indicates that you:

1. Have read and understood the above information.
2. Authorize and request payment under your vision insurance program to be made to Strasburg Family Eyecare, LLC. (Dr. Robert Lauver, III and/or Dr. Maia Moyer)
3. Accept financial responsibility for all fees incurred for services & products provided regardless of your insurance coverage.
4. Permit a copy of this authorization to be used in place of an original.
5. Records Releases: Must Submit in writing (form found: strasburgfamily.com), will take 48-72 hours, cost **$35**

Signature:_____ Date: _____

Appointment Policy: You must notify our office 48 Hours before your appointment if it is necessary to cancel. If you are a new patient and a 48-hour notice is not given, you will not be rescheduled.

1. **No Show/Cancellation policy** – If you cancel or no-show for an appointment with less than 48 hours of notice, you will be charged **$55.00.**
2. Repeated broken appointments and short-notice cancellations may be subject to dismissal from the practice.
3. IF you are more than 15 minutes late for your appointment, it may be cancelled and rescheduled.
4. School excuses are provided for children whose appointments must be scheduled during school hours.
5. As a courtesy, we will attempt to confirm your appointment 1 day in advance by phone.

Your signature below indicates understanding and acceptance appointment policy. This form will be kept on file in you or your child's charts.

Signature:_____ Date: _____