MedEye Associates
Surgery and Diseases of the Eye

What to expect during your visit at MedEye Associates

- **The first visit to the ophthalmologist requires a comprehensive evaluation that will take about one and a half hours. Your visit may take longer if you have a complex eye problem.**

- **Things that would be helpful to bring include your photo identification card, insurance card, referral if needed, medication list and any prior records if available.**

- **Once you have checked in, you will be greeted by a technician who will begin your work up. During this time the technician will ask you questions about your medical history, current medications and vision problems prior to seeing the physician.**

- **Following the work up, the technician may dilate your eye with dilating drops. These drops usually take effect in 20-30 minutes. After dilating your eyes, you will be asked to sit the low light waiting area. Your vision will be blurry and you may be sensitive to light. The effects of the dilating drops may last 3-4 hours (in some cases longer).**

- **Your physician may have ordered diagnostic testing for you, such as photographs/imaging, ultrasound, or intraocular lens (IOL) measurements. Access to same day diagnostic testing can extend your wait time. You may ask a staff member for alternative options.**

- **After all of your testing is complete you will be ready to meet your physician, who will have all of your test results available. The process completed at your visit prior to seeing the physician allows him/her to review your records, reach a diagnosis, and discuss a plan of treatment on that visit.**

- **At check-out please ask for paper sunglasses if you do not have your own.**

Should you have any questions during your visit, you may speak to any technician available. Thank you for choosing MedEye Associates as your eye care professional.

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Fax: (305) 661-6493

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Kendall Park Plaza
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Fax: (305) 385-9316

Pierini Esthetic Surgery
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MedEye Associates
Surgery and Diseases of the Eye

Qué puede esperar durante su visita a MedEye Associates?

Su primera visita al oftalmólogo, requerirá una evaluación completa, que tomará aproximadamente una hora y media. Su visita pudiese tomar más tiempo, si usted tuviese un problema ocular complejo.

A la hora de su visita, será conveniente que traiga una lista de los medicamentos que está tomando ó usando actualmente, su tarjeta de seguro, una identificación con su foto, su referido (si fuese necesario) y si es posible, notas o records previos.

Una vez que nuestro personal en la recepción lo haya registrado, será llamado por un técnico, que comenzará su labor de seguimiento. Durante este tiempo, se le harán preguntas sobre su historial médico, medicamentos y problemas previos de su visión.

El técnico pudiese dilatarle los ojos con gotas. Dichas gotas suelen hacer efecto en aproximadamente 20 a 30 minutos. Una vez dilatados, lo llevarán a un salón de espera de poca luz. Sus ojos se mantendrán dilatados durante 3 a 4 horas (en algunos casos más).

Pudiese ser que su médico haya ordenado algunas pruebas como:
Fotografías, imágenes, ultrasonido ó medidas para Lentes Intraoculares (IOL).
En el caso que se le hagan pruebas de diagnóstico, estos podrán extender su tiempo de espera. Nuestro personal le pudiese dar otras opciones.

Una vez hechos sus pruebas de diagnósticos, se los llevarán a su médico, quien las interpretará. Todo este proceso, le permitirá a su médico ver sus records, determinar su diagnóstico y poder discutir con usted un plan de tratamiento .

Al finalizar su visita, si nó tiene lentes de sol, pídale a la recepcionista que le de unos espejuelos desechables .
Si tuviese alguna pregunta durante su visita acerca de su tratamiento, puede preguntarle a cualquier técnico y si tuviese una pregunta acerca de su cita o futuras citas, puede preguntarle a cualquier miembro de nuestra recepción.

Gracias por haber escogido a MedEye Associates como su práctica oftalmológica.

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Date (Fecha) _____ Account#_____

Patient Name (Nombre de paciente) _____ Sex (Sexo) ___

Marital Status (Estado Civil) _____ Date of Birth (Fecha de Nacimiento) _____

Social Security # (Numero de Seguro Social) _____-_____-_____

Email Address (Direcion Electronica) _____

Home Phone# (Telefono de Casa) _____ Work (Trabajo) _____
Cell (Celular) _____

Address (Direccion) _____
City (Ciudad) _____State (Estado) _____ Zip Code (Codigo Postal) _____

Person Responsible for Bill _____
(Persona Responsable por la Cuenta)

Occupation (Ocupacion) _____Employer (Empleador) _____

Patient's Spouse or Parent (If Minor) _____
(Esposo (a) / Padres-Si es Menor)

Referred By (Referido Por) _____ Phone (Telefono) _____

Family Doctor (Medico Primario) _____ Phone (Telefono) _____

Insurance Carrier Name (Nombre Del Seguro) _____

Name, D/O/B, and SS # of the Subscriber _____
(Nombre, Fecha de Nacimiento y Numero de Seguro Social del Asegurado)

Allergies (Alergias) _____

Pharmacy Name _____ Phone_____
(Nombre de Farmacia) (Telefono)

May we discuss medical information with your spouse or family member?
(Nos autoriza discutir su informacion con su esposo/a- o algun familiar?)
N/A ___ Yes____ No____

-Signature (Firma) _____

EXPLANATION OF PAYMENT POLICY AND INSURANCE FILING PROCEDURES

INITIAL

ASSIGNMENT OF BENEFITS: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO MEDEYE ASSOCIATES OF ANY AND ALL MEDICAL BENEFITS APPLICABLE AND OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MEDEYE ASSOCIATES FOR CHARGES NOT COVERED BY THIS ASSIGNMENT. _____

RELEASE OF INFORMATION: I HEREBY AUTHORIZE THE MEDEYE ASSOCIATES FURNISH MY INSURANCE COMPANY OR COMPANIES, OR THEIR REPRESENTATIVES WITH ANY AND ALL INFORMATION THAT, MAY BE CONTAINED IN THEIR MEDICAL RECORDS. _____

LIFETIME MEDICARE B SIGNATURE AUTHORIZATION: I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS, OR TO THE BILLING AGENT OF MEDEYE ASSOCIATES ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS BE MADE TO THE HOLDER OF THIS ASSIGNMENT ON MY BEHALF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY HEALTH DEDUCTIBLES AND COINSURANCE. _____

MEDIGAP: I REQUEST THAT PAYMENT OF AUTHORIZED MEDIGAP BENEFITS BE MADE ON MY BEHALF TO MEDEYE ASSOCIATES FOR ANY SERVICES FURNISHED ME BY THEM. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO_____ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICE. I UNDERSTAND THAT I DO NOT NEED TO PROVIDE MY SUPPLEMENTAL INSURER WITH INFORMATION CONCERNING THIS MEDICARE CLAIM, BECAUSE MY SIGN IN THIS AUTHORIZATION WILL CAUSE MEDICARE PAYMENT INFORMATION TO CROSS OVER AUTOMATICALLY. _____

LIABILITY INSURANCE WAIVER: I HEREBY STATE THAT I WISH MEDEYE ASSOCIATES TO SUBMIT MY CLAIM FOR MEDICAL SERVICES TO_____FOR SERVICES RENDERED FOR THE ACCIDENT DATE OF_____. I AM NOT FILING THIS CLAIM WITH ANY OTHER LIABILITY INSURANCE AND WILL NOT BE MAKING ANY CLAIM TO ANY OTHER GENERAL LIABILITY INSURANCE OR COMPANY. I ALSO UNDERSTAND THAT IF I DO NOT SUBMIT THIS TO ANY OTHER GENERAL LIABILITY INSURANCE OR COMPANY THAT_____ WILL HAVE TO BE REFUNDED IMMEDIATELY AND THE TOTAL AMOUNT ORIGINALLY CHARGED FOR THE, SERVICES RENDERED WILL BECOME DUE AND PAYABLE BY ME, FILING YOUR LIABILITY INSURANCE DOES NOT CONSTITUTE AN ASSIGNMENT THIS IS A LEGAL CASE, WE DO NOT ACCEPT ASSIGNMENT PENDING THE OUTCOME OF YOUR CASE. YOU ARE RESPONSIBLE FOR YOUR BILL IN ITS ENTIRETY. _____

IF PATIENT IS UNDER 18: I HEREBY GIVE MY PERMISSION FOR_____

_____TO BE TREATED BY DR._____

_____ _____ _____

SIGNATURE / TELEPHONE VERIFICATION WITNESS DATE

PLEASE READ: THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. ALL CHARGES ARE DUE AT THE TIME OF SERVICE. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY DEDUCTIBLE, CO-PAYS AND NON-COVERED SERVICES NOT PAID BY MY INSURANCE COMPANY. IF A CHECK IS RETURNED, THERE WILL BE A $35 SERVICE CHARGE. IF MY ACCOUNT BECOMES DELINQUENT IN PAYMENT, I AGREE TO PAY ALL COSTS OF COLLECTION INCLUDING A REASONABLE ATTORNEY'S FEE.

METHOD OF PAYMENT: ❒ **CASH** ❒ **VISA** ❒ **M/C** ❒ **AMERICAN EXPRESS** ❒ **DISCOVER**

✔_____ ✔_____ _____

DATE PATIENT AND/OR GUARDIAN SIGNATURE WITNESS

THESE AUTHORIIZATION MUST BE SIGNED IN ORDER TO EXPEDITE THF FILING OF YOUR INSURANCE CLAIM.

MEDEYE ASSOCIATES
SURGERY AND DISEASES OF THE EYE

UNIVERSAL PATIENT AUTHORIZATION FORM FOR FULL DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT & QUALITY OF CARE

PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW

Patient (name and information of person whose health information is being disclosed):

Name (First Middle Last): _____ SSN: _____

Date of Birth (mm/dd/yyyy): _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

_____

You may use this form to allow your healthcare provider to see and obtain access to your health information. Your choice on whether to sign this form will not affect your ability to get medical care or health insurance coverage and cannot be used as the basis for denial of health services.

By signing this form, I voluntarily authorize and give my permission and allow disclosure:

OF WHAT: ALL MY HEALTH INFORMATION including any information about sensitive conditions (if any) [See page 2 for details]

FROM WHOM: ALL information sources [See page 2 for details]

TO WHOM: Specific person(s) or organization(s) permitted to receive my information (must be a healthcare provider):

Person/Organization Name: _____ Phone: (____) _____

Address: _____ Fax: (____) _____

PURPOSE: To provide me with medical treatment and related services, and to evaluate and improve patient safety and the quality of medical care provided to all patients.

EFFECTIVE PERIOD: This authorization/permission form will remain in effect until the day I withdraw my permission.

WITHDRAWING MY PERMISSION: I can withdraw my permission at any time by giving written notice to the person or organization named above in "To Whom."

In addition:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other persons [See page 2 for details].
- **I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.**
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

X _____ _____

Signature of Patient or Patient's Legal Representative — Date Signed (mm/dd/yyyy)

_____

Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

- ☐ Parent of minor
- ☐ Guardian
- ☐ Other personal representative (explain: _____)

Patient E-mail Address: _____

NOTE: This form is invalid if modified. You are entitled to get a copy of this form after you sign it.

Explanation of Form Florida AHCA FC4200-004
"Universal Patient Authorization for Full Disclosure of Health Information for Treatment & Quality of Care"

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

"Of What": includes ALL YOUR HEALTH INFORMATION, INCLUDING:

1. **All records and other information regarding your health history, treatment, hospitalization, tests, and outpatient care. This information may relate to sensitive health conditions (if any), including but not limited to:**
    a. Drug, alcohol, or substance abuse
    b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)
    c. Sickle cell anemia
    d. Birth control and family planning
    e. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
    f. Genetic (inherited) diseases or tests
2. **Copies of educational tests or evaluations, including Individualized Educational Programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height, weight), and information about injuries or treatment.**
3. **Information created before or after the date of this form.**

"From Whom" includes: **All information sources** including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources that may have some of my health information (schools, records administrators, counselors, etc.), social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker's compensation programs, state Medicaid, Medicare and any other governmental program.

"To Whom": For those health care providers listed in the "TO WHOM" section, your permission would also include physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified. Disclosure may be of health information in paper or oral form or may be through electronic interchange.

"Purpose": Your signature on this form does NOT allow health insurers to have access to your health information for the purpose of deciding to give you health insurance or pay your bills. You can make that choice in a separate form that health insurers use.

"Withdrawal": You have the right to revoke this authorization and withdraw your permission at any time regarding any future uses. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

"Re-disclosure of Information": Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

Limitations of this Form: If you want your health information shared for purposes other than for treating you or you want only a portion of your health information shared, you need to use Form Florida AHCA FC4200-005 (Universal Patient Authorization Form For Limited Disclosure of Health Information), instead of this form. Also, this form cannot be used for disclosure of psychotherapy notes. This form does not obligate your health care provider or other person/organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.

Note to recipient(s) of the information disclosed under this permission: This information may have been disclosed to you from records protected by state and/or federal confidentiality rules (42 CFR Part 2 or 38 CFR Part 1). If so, the state and/or federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by state law and/or 42 CFR Part 2 (e.g., certain medical emergencies) or 38 CFR Part 1. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient or patient with sickle cell anemia or HIV infection.

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under 45 CFR Parts 160 and 164 ("HIPAA"); Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. No. 111-5 (Feb. 17, 2009) §13405 ("HITECH Act"); 42 U.S. Code §290dd-2; 42 CFR Part 2; 38 U.S. Code section 7332; 38 CFR 1.475 (Veterans Affairs); 20 U.S. Code §1232g ("FERPA"); 34 CFR parts 99 and 300; Florida Statute 408.051(4) ("Universal Patient Authorization Form"); and all other Florida Statutes, the Florida Constitution, Florida regulations or administrative rules requiring patient authorization, consent or permission to release such records (including but not limited to Florida Statutes §456.057(7)(a), §395.3025(4), §394.4615(2)(a), §381.004, §397.501(7), §760.40(2), §392.65(1), §384.29(1), and §385.202(3)).

MEDEYE ASSOCIATES
SURGERY AND DISEASES OF THE EYE

Consent for Disclosure of Medical Information
(Permiso para divulgar su condición médica)

I, _____, hereby allow and give consent for the following family members, friends or health care surrogates to accompany me in the exam room during my visit or discuss my health information with the physician:

Yo, _____, autorizo a los siguientes familiares, amistades o personas a cargo de mi bienestar, a presenciar o discutir mi condición de salud durante mi visita con el médico:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

May we leave a message on your answering machine, cell phone, or with the person that answers the phone?
Nos permite dejar in mensaje en su grabadora, celular, o con la persona que conteste el teléfono?

_____ Yes (Si) _____ No

_____
Signature of Patient or Guardian
(Firma del paciente o guardian)

_____
Date / Fecha

_____
Signature of Witness
(Firma del testigo)

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MedEye Associates
Surgery and Diseases of the Eye

Dear Patient:

REFRACTION

If you are here for a new pair of glasses to improve your vision, then a test called "REFRACTION" must be done. In the past, this test was included in your complete eye exam at no additional charge. However, most insurance plans no longer cover the cost of refractions. Please check with your insurance plan. They may offer the refraction and eyewear to you at no charge at a participating Optometrist's Office. Our fee for the Refraction is $35.00.

ROUTINE EYE EXAM

If you are here for a complete eye exam to correct visual defects such as myopia, astigmatism, etc, and have no medical conditions, the exam is considered a ROUTINE EYE EXAM and is not covered by most health insurance companies. Our Front Desk staff will let you know if your insurance company will cover these services if done here at Med Eye Associates. Our fee for the Routine Exam is $65.00

If you choose to have the REFRACTION and/or complete ROUTINE eye exam done here at MedEye, the charges are due at the time services are rendered.

MEDICARE PATIENTS: Medicare will not reimburse you for the refraction or the routine eye exam. It is considered a non-covered service under both Medicare and Supplemental Secondary Insurance.

I understand the above and agree to pay the $35 Refraction or the $65 Routine exam whichever is applicable.

I acknowledge I have read the above information.

Patient Signature:_____Date:_____

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Estimado Paciente:

REFRACCION

Si UD. viene para mejorar su visión por medio de espejuelos, o sea, para saber si necesita una prescripción, entonces necesita una REFRACCION. En el pasado, este exámen estaba incluído en el exámen completo y no se cobraban gastos adicionales. Sin embargo, este ya no es el caso. La mayoría de las compañías de seguro no cubren refracciones. Por favor llame a su compañía de seguro. Es posible que le ofrezcan la refracción o los espejuelos gratis ó a un precio bajo si fuera a uno de los optometristas que pertenecen a su plan. El costo de la refracción es $35.00.

EXAMEN DE RUTINA

Si UD. viene para un exámen completo para corregir un defecto de la vista como astigmatismo, miopía, etc., y no tiene una condición médica, este exámen es considerado un EXAMEN DE RUTINA y no está cubierto por la mayoría de las compañías de seguro. Nuestro personal en la recepción le dejará saber si su compañía de seguro cubrirá su visita de hoy. El costo del exámen de rutina es $65.00.

Si UD. desea hacerse la refracción ó el exámen completo, los cargos deberán ser pagados a la hora de su visita.

PACIENTES DE MEDICARE: Medicare no le cubrirá la refracción ni el exámen de rutina. Estos servicios son considerados preventivos y no están cubiertos por Medicare ni por su seguro suplementario.

Yo entiendo lo descrito anteriormente y estoy de acuerdo en pagar $35.00 por la Refracción ó $65.00 por el Examen de Rutina.

Hago constar haber leído la información anteriormente descrita.

Firma del Paciente: _____ Fecha: _____

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Payment Policy

Thank you for choosing MedEye Associates as your eye care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance:** We participate in most insurance plans, including Medicare and Medicaid. If you are not insured by a plan, payment in full is expected at each visit. If you are insured by a plan, but we did not have an updated insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles:** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payments at each visit.
3. **Non-covered services:** Please be aware that rarely some of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. You will be told about this before services rendered.
4. **Proof of insurance:** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and a current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely matter, you will be responsible for the balance of the claim.
5. **Claims submissions:** We will submit you claims and assist you in any way we reasonably can to help get your claim processed. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes and help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. **Nonpayment:** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you or your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30 day period, our physician will only be able to treat you on an emergency basis.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges of the area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient or responsible party Date

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MedEye Associates
Surgery and Diseases of the Eye

Póliza de Pago

Gracias por elegir MedEye Associates como su proveedor para el cuidado de los ojos.
Estamos comprometidos en brindarle la calidad y la atención que su salud merece.
Debido a múltiples preguntas generadas sobre de la responsabilidad monetaria del paciente y la cobertura de seguros por los servicios prestados, hemos decidido realizar una póliza de pago.
Por favor lea detenidamente, si tiene alguna pregunta infórmenos.
Una copia de esta póliza se le será entregada, si usted así lo desea.

Seguro Medico: Aceptamos la mayoría de los seguros médicos, incluyendo Medicare y Medicaid.
Si no está cubierto por un plan medico, el pago total deberá ser cancelado al momento de cada visita.
Si usted está cubierto por un plan, pero no tiene una tarjeta de seguro actualizada o vigente, el pago completo por cada visita será necesario hasta que podamos verificar su cobertura médica.
El conocimiento total de sus beneficios es responsabilidad del paciente.
Por favor, póngase en contacto con su compañía de seguros, si tiene alguna pregunta relacionado con sus beneficios.
Co-pagos y deducibles: Todos los co-pagos y deducibles deben ser cancelados al momento de la visita.
Este acuerdo es parte de su contrato con su compañía de seguros. Ayúdenos a cumplir con la ley cancelando co-pagos o deducibles al momento de la visita, ya que de no ser así estaríamos cometiendo fraude.
Servicios no cubiertos: Tenga en cuenta que alguno de los servicios médicos que usted necesita pueden no estar cubiertos por su seguro. Usted será responsable del pago de estos servicios al momento de la visita. Esta opción será discutida con usted antes de proveerle los servicios.
Constancia de seguro medico: Todos nuestros pacientes deberán llenar los papeles necesarios antes de ver al doctor. Necesitaremos copia de su Licencia de conducir al igual que la tarjeta del seguro medico como constancia de su cobertura medica. En caso de no recibir la información correcta, el paciente será responsable por cualquier pago pendiente.
Cobro al seguro: Enviaremos el cobro por los servicios prestados a su seguro medico y cooperaremos para que sus servicios sean procesados y pagados de la mejor manera posible. Su seguro medico puede necesitar información adicional, la cual usted deberá enviar en el tiempo estipulado por su seguro. Tenga en cuenta que usted será responsable por cualquier pago que su seguro no realice. Los beneficios pagados por su seguro es un contrato entre usted y su seguro; nuestra compañía no es parte de dicho contrato.
Cambio en su cobertura medica: Si su seguro medico cambia, por favor notifíquenos antes de su próxima visita, para que nuestro personal pueda hacer los cambios necesarios y podamos ayudarle a recibir sus beneficios al máximo. Si su seguro medico no cancela la deuda con nuestra practica en un periodo de 45 días, el balance automáticamente pasara a ser responsabilidad del paciente.
Cuentas pendientes por falta de pago: Si su cuenta pasa de 90 días sin pago, usted recibirá una carta explicándole que tiene 20 días para pagar en total su deuda. Pagos parciales no serán aceptados. Tenga presente que si no cancela la deuda, su cuenta será enviada a una agencia de colección, y cualquier miembro perteneciente a su seguro que sea paciente de nuestra práctica será expulsado de la misma. Si esto sucede, usted y sus familiares serán notificados por medio de una carta certificada, donde se le darán 30 días para buscar otro medico que pueda atenderlo.

Nuestra práctica esta comprometida en brindarle el mejor servicio, por lo tanto nuestros precios son los usuales en el área. Muchas gracias por leer y entender nuestra póliza de pago. Por favor notifíquenos si tiene alguna pregunta, o duda al respecto.

Por medio de mi firma, afirmo que he leído y entendido la póliza de pago y estoy de acuerdo con todos los términos explicados en la misma:

Firma Del Paciente _____ **Date** _____

5858 S.W. 68th Street
Miami, Florida 33143
Telephone: (305) 661-8588
Fax: (305) 661-6493

Coral Reef Medical Park
9299 S.W. 152nd Street, Suite 101
Miami, Florida 33157
Telephone: (305) 661-8588
Fax: (305) 661-6493

Portofino Professional Center
925 N.E. 30th Tea, Suite 216
Homestead, Florida 33033
Telephone: (305) 661-8588
Fax: (305) 661-6493

Kendall Park Plaza
16269 SW 88th Street, Suite B-106
Miami, Florida 33196
Telephone: (305) 661-8588
Fax: (305) 661-6493

Pieraini Esthetic Surgeay
8353 NW 36th Street
Doral, FL 33166
Telephone: (305) 661-8588
Fax: (305) 661-6493

MedEye Associates
Surgery and Diseases of the Eye

24 Hours Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, prevents another patient from receiving care. Therefore, MedEye Associates reserves the right to charge a $25.00 fee for all missed appointments ("No Shows") without prior cancellation within 24 hours of scheduled appointment.

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "no Shows" in any 12 months period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Print Name Date

_____

Signature