Patient Name: _____
Please PRINT

Office Financial Policy

We request all office charges or co-pays to be paid at the time of service by cash, check or credit card. An "Attending Physician's Statement" will be sent to your insurance company to assist you in obtaining reimbursement for covered expenses. Collection from your insurance is your responsibility. "I agree to be responsible for the payment of all charges and pay for all costs of collection and legal fees." If we do not receive your monthly payment, your account will be charged $4.78 for the cost of monthly billing.

Currently, some insurance companies are denying payment for Refraction(92015), the determination of the best glasses or contact lens prescription as non-covered service. "If my insurance denies payment, I agree to be personally and fully responsible for payment of $40.00."

I authorize Dr. Daynes to furnish to my designated insurance carrier(s) all pertinent information and records concerning my current illness or injury. I also authorize benefits under my insurance claim to be paid directly to the doctor listed above.

I have read, understand, and agree to the provision of Daynes Eye & Lasik Financial Policy.

_____ ☐ Patient ☐ Parent / Guardian
Signature Date

Medicare Patients

PHYSICIAN NOTICE

"Medicare will only pay for services that it determines to be reasonable and necessary under section .1862(2) (1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is not reasonable and necessary under Medicare program standards, Medicare will deny or reduce payment for that service." ***Currently Medicare is denying payment for Refraction (92015), the determination of the best glasses or contact lens prescription, as non-covered service***.

BENEFICIARY NOTICE

I have been notified by my physician that he or she believes that, Medicare is likely to deny payment for the service identified above, for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Daynes Eye & Lasik, for services furnished me by my physician. I authorize any holder of medical information about me to be released to the Health Care financing Administration and its agents any information needed to determine these benefits or the benefits payable to related service.

_____ ☐ Patient ☐ Parent / Guardian
Signature Date