Patient Financial Responsibility Policy

Our office provides a full scope of eye care services including routine vision care (i.e.: check-ups, glasses and contact lenses), as well as medical eye care services such as treatment for eye infections, dry eye and lid disease, treatment and evaluation of ocular allergy, cataracts, glaucoma and trauma related care. Payments for all services rendered by this office are the responsibility of the patient. Depending on the nature of your visit, we may be able to bill your vision plan insurance, your medical insurance or both. Please present all of your insurance information to the receptionist upon arrival.

So that we may efficiently process you claims, please be sure your insurance information is current and accurate at the time of service. A copy of your insurance card must be given at each appointment.

Although we do call for benefits prior to your visit, please remember that any information received from your insurance company is strictly an estimation of benefits and is not a guarantee of payment. Your co-pay, deductible, co-insurance, as well as any non-covered services from your visit is due at the time of service. Ultimately, you are also responsible for all charges that are returned or denied or non-covered once your claim has been submitted and processed by your insurance provider. If you feel that your claim has been inaccurately denied for something other than a filing error on our part, it will be your responsibility to dispute the denial with your insurance company. You will be responsible for any remaining balance on your account.

All patients are responsible for completely filing out a patient registration form for our office every year or any time there is a change in your information. Since we are extending you credit (you are receiving treatment prior to us being paid) we require the following information from you: Current drivers' license or ID card, date of birth and Social Security Number. (Responsible party if child is a minor or otherwise not responsible for the charges.) If you do not wish to give us this information, we can see you on a cash basis only and you will be responsible for sending claims to your insurance company.

Jeffery E. Gates, OD & Associates, will bill you directly for all charges related to your visit in the event that:

A. Your insurance does not cover the services provided because Jeffery E. Gates & Associates is not a Participating Provider on your plan;
B. Your insurance coverage is not in effect at the time of your visit;
C. A non-covered service or procedure is performed;
D. Your insurance company denies payment for any reason other than stated in A, B, or C above.

Your insurance company will provide you with an explanation for any services for procedures denied by your plan.

The responsibility for payment of services rendered to any dependent children whose parents are divorced rests with the parent who seeks treatment. Any court ordered responsibility judgement must be determined between the individuals involved without the inclusion of our office.

Balances due, notwithstanding insurance balances, that are not paid in full within 30 days may be turned over to an outside collection agency for final payment. In the event that an account is turned over to collections a fee equal to the amount charged by the collections company/attorney may be assessed.

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to myself or to the party who accepts assignment, Jeffery E. Gates, OD & Associates. I authorize payment of medical benefits to the undersigned physician or supplier for services as described.

Your signature indicates that you have read, understand, and agree to all the above policies. As a responsible party, your signature indicates acceptance of the above policies and authorizations.

Date: _____

Patient Name _____ Patient Date of Birth _____

Signature _____ Relationship to Patient _____

(Signature of responsible party if not the patient)

revised 10/01/2015