

## **Patient Financial Responsibility**

### **Insurance**

- Please provide all insurance cards (if you are not provided with a card please advise us at check-in). We can only file those claims with which we have a current participation contract. For coverage with other carriers, we will provide you with a statement of services, which you may file with that carrier on your own.
  
- Many insurance companies require that you have a referral from your Primary Care Physician (PCP) before our physicians can see you for an appointment. If you have questions regarding coverage or to see if it's necessary to obtain a referral for your next visit, please call the Member Services number located on your insurance card or your Primary Care Physician. If a referral is necessary. It must have an expiration date that covers your next visit to this practice. With most insurance companies and authorization or referral **does not guarantee** services will be covered.
  
- If a referral is required, and you do not have one, some insurance companies will allow you to be seen by the physician. However, they require you to sign a waiver stating that you realize a referral was necessary, that you do not have one and that you will pay the cost of the visit. If your insurance company does not allow us to see you without a referral or a waiver, we will be required to reschedule your appointment.

### **Non-Covered Services**

- “Refraction” is a procedure necessary for physicians to evaluate your vision and/or write glasses prescription. Unfortunately, Medicare and most insurance plans do not cover this procedure. The cost of the refraction is \$20.00 and is considered the patient’s responsibility. (Occasionally, there may be other necessary procedures that fall under this policy.)

### **Medical Records Policy**

- Patients may view the original chart in our office. A physician or staff member must be present.
  
- Patients may obtain a copy of their records. A records release signed and dated by the patient, patient’s guardian or other duly authorized representative is required.

**I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account. All co-pays and fees for non-covered services are due at the time services are rendered. Co-payments do not include refractions or other non-covered services. Fees mentioned in this document are subject to change without notice. I understand that all fees are my responsibility regardless of providing an insurance plan for payment. I authorize release of any information necessary to process my insurance claim and assign and request payment directly to Glaucoma Institute of Austin.**

**I have read and understand the above. I have had the opportunity to ask questions.**

\_\_\_\_\_  
Patient’s or Guarantor’s Signature

\_\_\_\_\_  
Guarantor’s Printed Name

\_\_\_\_\_  
Date