Heimer, Fiore, Turco Eye Care & Surgery

Financial Responsibility Policy

1. All patients with traditional health insurances/Medicare/Medicare Managed Advantage plans:

I request payment of authorized benefits to be made on my behalf to Heimer, Fiore, Turco Eye Care & Surgery for services rendered to me. I authorize pertinent medical information to be released to the insurer I have indicated in order to determine benefits payable for related services. My signature below authorizes release of medical information to a secondary insurer, if applicable. Heimer, Fiore, Turco Eye Care & Surgery accepts the Medicare and participating insurance company's determination of allowable charge. I am responsible for deductibles, coinsurance, co-pays and non-covered services (see example below).

2. Patients with Supplemental Insurance:

I understand that if a Medicare supplemental policy or other secondary health insurance is indicated, my signature authorizes release of the information to the insurer indicated. I request that payment of authorized secondary insurance benefits be made on my behalf to Heimer, Fiore, Turco Eye Care & Surgery If paid to me, I will forward same to Heimer, Fiore, Turco Eye Care & Surgery.

3. Non-covered Services (All Patients):

I understand that Heimer, Fiore, Turco Eye Care & Surgery contracts with health care insurance plans relate only to items and services which are covered by the insurance plans. Accordingly, I accept full financial responsibility for all items or services which are determined by the health care insurance plans not to be covered. I agree to cooperate with Heimer, Fiore, Turco Eye Care & Surgery to obtain necessary authorizations. I acknowledge that treatment decisions are made by Heimer, Fiore, Turco Eye Care & Surgery solely based on medical necessity. Availability of insurance coverage is not a factor in this decision-making process.

4. Financial Responsibility Agreement (All Patients):

I agree that in return for the services provided by Heimer, Fiore, Turco Eye Care & Surgery, I will pay my account balance at the time of service, or I will make financial arrangements satisfactory to Heimer, Fiore, Turco Eye Care & Surgery. If my account becomes delinquent, it may be sent to an outside collection agency

If a co-payment or deductible is designated by my insurance company or health plan, I agree to pay it to Heimer, Fiore, Turco Eye Care & Surgery at the time of service. I understand that if I come to my appointment unprepared to pay, my appointment may be rescheduled, or a billing fee incurred in addition to the co-payment. I also understand that I am responsible for the copayment of any special testing.

I understand that I am responsible for payment of my bill. I am aware there will be a $20 charge per incident for returned checks.

Examples of non-covered services:

-Refraction for glasses- $51 **A refraction is a test that tells your doctor if you need prescription lenses, as well as what prescription lenses you need to see properly.

-Contact lens fitting- ranging from $75-$125

Signature:_____Date:_____