WEST COAST EYE CARE ASSOCIATES
BARRY KATZMAN, M.D., P.C. MEDICAL DIRECTOR
Diplomate American Board of Ophthalmology

Office and Financial Policies

We would like to thank you for choosing West Coast Eye Care (WCEC) as your medical provider. To keep you informed of our current office and financial policies we ask that you read and sign our financial acknowledgement prior to any treatment. Please keep this document for future reference.

Canceled Appointments: If you are unable to keep your scheduled appointment, please call our office within 24 hours to reschedule your appointment. This will enable us time to use your slot for another patient.

No Insurance: Payment will be due at the time of service for materials, exam, testing and minor surgeries. If you are unable to pay your balance in full, you will need to make prior arrangements with our Front Desk Manager or Business Office Manager. If services are rendered and payment is not made on the same day, a $15 charge will be added to your bill for services provided.

Insurance: WCEC will try to bill your insurance as a courtesy. We cannot warranty insurance payments. Please bring your insurance card with you at the time of your appointment. For insurance plans that we contract with, your carrier requires that all co-pays be paid prior to any services being rendered. The co-pay requirement cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. If you do not have your co-pay at the time of your visit, you must provide us a written waiver from your insurance carrier specifically authorizing WCEC to waive this obligation. You are responsible for any co-insurance, deductibles or non-covered services as required by your insurance. You will receive a statement from our office indicating what your insurance has paid. Any remaining balance is due upon receipt of that statement. If your deductible and or co-insurance are not paid on time, a $15 charge will be added every time we have to bill you. Should your account be assigned to a collection agency, you will be responsible for any additional fees charged by the collection agency.

HMO or POS: For POS and HMO insurance plans that we participate in, your insurance carrier requires that you obtain a referral from your Primary Care Physician (PCP) before receiving services. Please bring that referral with you. Any services received without a referral or proper authorization will be your responsibility.

Return Checks: A $25.00 charge will be added to your account for any check returned by your bank for any reason.

Disability or Insurance Forms: There will be a minimum charge of $10.00 for the completion of medical forms (charge is based upon number of pages and complexity of information requested). Payment is due at the time that you pick-up the forms. Please allow 7 – 10 days for the completion of these forms. If you would like the forms mailed to you or your insurance company, payment will be due prior to mailing.

Medical Records: We will provide you a copy of your medical records upon request. You will need to sign a letter of release at the time of drop-off. Please allow 7-10 days for us to copy your records. You may be charged for additional copies of your medical record. Rates charged are within California state statutes.

PATIENT NAME_____ Date _____

Patient Financial Responsibility

I acknowledge full financial responsibility for services rendered by West Coast Eye Care Associates (WCEC). I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance, including coinsurance, deductibles and copays. I understand payment of co-pays is expected at time of service, as well as any prior balance I may owe. I also consent that the payment of authorized Medicare insurance benefits be made on my behalf directly to WCEC for any medical or surgical services furnished. I agree to all reasonable attorney fees and collection costs in the event of default of payment of my charges, as outlined in office and financial policies guidelines.

Signed _____ Date _____

Consent for Purposes of Treatment, Payment and Healthcare Operations

I hereby give my consent to WCEC to use or disclose, for the purpose of carrying out treatment, payment, or healthcare operations, all protected health information contained in the patient

record of_____. For a more detailed description of this consent and other uses and disclosures please review our Notice of Privacy Practices. I understand that WCEC reserves the right to change its privacy practices that are described in the Notice. I also understand that any Revised Notice will be posted on WCEC's website, available at each office or I may request a copy be sent to me by mail. I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signed _____ Date _____

Acknowledgment – Notice of Privacy Practices

I hereby acknowledge receipt of WCEC's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential health information. I understand that WCEC has reserved the right to change its privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided or made available to me.

Signed _____ Date _____

If you are not the patient, please specify your relationship to the patient

Name _____ Relationship _____ Date _____