



# Thames Eye Group

*Your Eyes Are Our Specialty!*

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## Receipt of the Notice of the Privacy Practice

We reserve the right to modify the practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices.

### Patient Financial Policies

As you know, health care is in a state of constant change. In order to help you with these changes we require every patient to present his most recent insurance card at each visit so we have accurate information on file. If you do not have your insurance cards payment in full will be required at time of service. Please read and initial the following statements regarding your financial responsibility.

1. I understand I am financially responsible for all services rendered. It is my responsibility to be aware of the rules and regulations imposed by my insurance carrier. \_\_\_\_\_ INITIAL

2. I understand this office participates with certain health insurance. If my insurance is accepted, they will bill my insurance. I am responsible for any deductible, copays and payment for non-covered services at the time of my visit. A fee of \$10.00 will be charged for all copays not paid at time of service. A fee of \$25.00 will be charged for any returned checks. \_\_\_\_\_ INITIAL

3. I understand that if I am covered under a gatekeeper plan (such as Oxford, BlueCare, etc.) I need to obtain a referral from my primary care physician prior to my appointment. I realize if I do not have this referral the office may choose to reschedule my appointment. \_\_\_\_\_ INITIAL

4. If it becomes necessary for Thames Eye Group to forward my account to a Collection agency, I understand that I will be responsible for additional fees incurred. \_\_\_\_\_ INITIAL

I understand the policies stated above and accept responsibility for payment of all charges for the patient.

I, \_\_\_\_\_, hereby authorize Thames Eye Group, P.C. to apply for benefits in my behalf for covered services rendered. I request payment from the insurance carrier to be made directly to Thames Eye Group, P.C. I authorize the release of any necessary information, including medical information for this or any related claim to the billing agent.

I permit a copy of this authorization to be used in place of the original.

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SIGNATURE OF PATIENT OR REPRESENTATIVE

DATE