WINTHROP EYE CENTER

42 Woodside Avenue
Winthrop, MA 02152
P: (617) 213-2131
F: (617) 213-2001
drmel@winthropeyecenter.com
www.winthropeyecenter.com

FINANCIAL POLICY / MEDICAL RELEASE / SIGNATURE ON FILE

It is the patient/parent/guardian's responsibility to:

- Be familiar with the benefits of your plan; including co-pays, co-insurance, and deductibles.
- Bring all of your current insurance cards to all visits.
- Provide our office with current information, including address, phone numbers, driver's license or ID, and employer.
- Be prepared, in accordance with your insurance contract, to pay your co-payment at the time of the visit.

Benefits for services are based upon your individual insurance coverage and we cannot guarantee the payment by your insurance. Be advised that a diagnosis will not be modified to fit your plan benefits.

> For example, some insurance companies (including Medicare) do not pay for refractive part of the examination. If refraction is necessary, these insurance carriers will deny the claim. Therefore, the patient will be responsible for the refraction charge as well as for any other non-covered services.

If we do not receive payment in a timely fashion, your account may be referred to an outside firm for collection. If this occurs, you will be responsible for all collection and attorney fees.

For all services rendered to minor/dependent patients, we will look to the adult accompanying the patient and/or the parent/guardian for payment. When presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply their name, address, phone number, date of birth and social security number. We request that you inform the subscriber that their insurance has been used.

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I have read and understood the above financial policy.

By signing this statement, I authorize payment for all insurance benefits for services rendered by this office be made payable to Winthrop Eye Center, LLC (for Winthrop Eye Center associated providers: Dr. Esendal or Melda N. Gerow) at the following address: 42 woodside Avenue, Winthrop, MA, 02152.

I understands that I am responsible for co-payments, co-insurance, deductibles and for services not covered by my insurance plan.

I authorize Winthrop Eye Center to release any information necessary to determine the benefits payable for related services to the appropriate insurance agencies.

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

_____
Signature of Patient or Legal Representative

Name _____

Date _____

If signed by a legal representative, relationship to the patient _____

This form is valid until indicated by the above signee in writing of other arrangements.