Colorado Family Eye Centers

Children's Eye Physicians

Colorado Center *for* Eye Alignment

Patient/Parent email: _____

(This is how Children's Eye Physicians communicates with the patient/parent regarding billing, office closures, reminders for appointments etc.)

Patient's vision insurance is: **VSP** **EYEMED** **SPECTERA** **OTHER** **NONE**

Does the patient wear contact lenses? **YES** **NO**

Is the patient expecting to discuss contact lenses with the doctor today? **YES** **NO**

Is the patient wanting to update their contact prescription at today's visit? **YES** **NO**

Medical & Vision Insurance:

Your insurance policy is a contract between your employer and/or you and the insurance carrier. Children's Eye Physicians is not a party to that contract. Your coverage, the requirements for co-payments, deductibles, and co-insurance as defined in your policy is your responsibility. Be aware there will be an additional fee for services such as, contact lens services, refraction, and other tests that may or may not be covered by your medical insurance or vision insurance. Your insurance plan or the federal government determines the range of benefits available to you. It is your responsibility to know your insurance coverage.

Credit Card/Check on File Requirement:

Children's Eye Physicians require patients to sign an agreement with us via our secure credit card merchant, WayStar (Merchant Services) to keep a credit, debit, or check on file which will automatically be charged for the patient responsibility portion upon receipt of the insurance explanation of benefits (EOB). You will receive an email notification 3 days prior to processing the amount of patient responsibility to the credit card, debit card, or check on file. This gives you an opportunity to call our office within that timeframe if you have questions or concerns about your balance. We accept Visa, MasterCard, Discover, American Express credit cards, debit cards, and checks. Please be aware that depending on services, we may require the patient's responsibility portion is paid at time of service. If an overpayment is inadvertently collected, a refund will be issued.

Payment Policy:

Children's Eye Physicians will bill your insurance carriers as a courtesy and accept their negotiated rate for the charges billed. However, you will be responsible for any balance deemed patient responsibility by your insurance. Payment is expected in full at time of service or through the credit card/check on file requirements. You are responsible for any unpaid charges for services rendered. Defaulting on a patient balance or payment plan may cause your account to be turned over to a collection agency. You will be responsible for and any collection, attorney or court fees incurred which includes a 30% fee for any balance going to collections.

Release of Information:

I authorize Children's Eye Physicians to release the medical records concerning this patient to any covered entity involved in their care.

Assignment of Benefits:

I authorize my insurance carrier to assign all surgical, medical or routine benefits directly to Children's Eye Physicians. I authorize release of medical information necessary to process all insurance claims.

_____ _____

Patient Name **Date of Birth**

_____ _____

Signature of Patient/Guardian **Date**

Your vision is our mission