PEDIATRIC EYE CARE & SURGERY
Sarah J. Whang, M.D.

FINANCIAL POLICY

Child's Name:____ **Child's DOB**:__________________

The following items are to be paid for at the time of your visit:
- Co-payments
- Co-insurance amounts
- Deductibles
- Refractions

_____ Initials **Routine eye examinations and refractions** are **NON**-covered services by most medical insurance companies. **If my child does not have a medical problem with his/her eyes, which can be determined only after Dr. Whang's examination, then I will be responsible for payment of services (unless my medical insurance provides coverage for a routine eye exam).** A refraction is needed to determine if my child needs glasses. If my child wears glasses, the refraction is required to update the glasses prescription. **I am responsible for payment of the refraction fee at the time of service as required by Dr. Whang's billing company.** If the refraction is a covered benefit, a refund check will be issued.

_____ Initials My medical insurance will reimburse only those services that are covered by my policy. It is my responsibility to know which services are covered by my policy. **It is my responsibility to pay any fees for any services that are not covered by my policy. Dr. Whang does not participate with any vision plans and will bill only my medical insurance, not vision insurance.**

_____ Initials The parent/guardian bringing the child to the office is responsible for the full amount of any fees due. Partial payments will not be accepted.

_____ Initials **Miscellaneous Fees:**

- **A rescheduling fee of $50 will need to be paid in order to reschedule a missed appointment for which 24 hours advance notice has not been given, regardless of whether or not the courtesy reminder phone call was received.** A voicemail message left 24 hours in advance will serve as sufficient notice. It is my responsibility to inform the office of any changes in my phone number. The rescheduling fee is subject to change.
- A fee of $20.00 will be added to my account for a returned check. In case of default, my account will be turned over to a collection agency, and 10% interest per year will be added.

_____ Initials If the health insurance information provided by myself is not true or if I am not eligible under the terms of the Medical Subscriber Agreement, I am responsible for any and all charges for services rendered. **I agree to pay in full within 30 days of receiving a bill from this office.** It is my responsibility to inform the office of any mailing address changes.

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS: I hereby authorize the release of any medical information necessary to process insurance claims and authorize payment of benefits to Pediatric Eye Care & Surgery.

I certify that I have read and fully understand and accept the above financial policy.

Signature of Responsible Party: ____

Please print Name of Responsible Party: ____

Relationship to Patient: ________________________________Date Completed: _____________________