Practice Policies

1. I am responsible for providing Spectrum Eye Institute (SEI) with my current insurance cards/ID at every visit. Claims for insufficient/incorrect information are my responsibility to pay.
2. I am responsible for obtaining HMO referrals for my appointments. Failure to so will result in rescheduling my appointment.
3. I am responsible for verifying my insurance coverage and network status prior to coming in for my appointment. It is the patient's responsibility to know whether their insurance plan is in network with our practice.
4. If the patient is a minor, the parent present at the appointment is financially responsible.
5. Co-payments, deductibles, account balances, co-insurance and refraction charges are due at the time services are rendered or my appointment will be rescheduled. I am aware that payments collected for procedures are estimates. Accounts will be reconciled after your insurance company processes the claim. You will be billed for any remaining balance.
6. Medical and vision charges cannot be billed at the same appointment. If a prescription for glasses (refraction) is requested, the patient is responsible for a $65 fee at the time of service.
7. We request a 24 hour cancellation notice. Failure to call/no shows will be charged an administrative fee not billable to insurance. When cancelling you must know who you spoke to, the date/time. Fines are as follows: Surgery $200, in office procedures $75, appointments $50. The patient cannot reschedule their appointment/surgery until the fee is paid.
8. Spectrum Eye Institute attempts to make courtesy phone calls or texts for appointment reminders, but we are unable to provide this service at all times. Lack of a reminder call or text does not cancel the above no-show policy.
9. All returned checks will be charged a $30 fee and your account will be placed on a cash or credit card only basis.
10. Invoices are due upon receipt.
11. If an account balance goes 90 days with no correspondence by you, your account will be placed in collections. If we are forced to turn your account over for collection you will be charged the collection fess which are usually 50% of the remaining balance and all other incidental fees.
12. A fee of $10-$25 will be charged for each form that needs to be filled out by our staff. Payment will be due when we receive the form.
13. There will be a charge incurred for copying medical records being released to the patient. Fees will be determined by Spectrum Eye Institute upon review of the entire chart and will be due by the patient.
14. All prescription refill requests must be e-scribed or faxed by the patient's pharmacy to our office.

I have read and understand the practice policies

_____ _____

Signature Relationship (if other than patient)

_____ _____ _____

Print patient name Date Date of birth

Phone: Home_____ Cell: _____

Revised 11/21/24

ACKNOWLEDGMENT FORM

I have received Notice of Privacy Practices, and I have been provided an opportunity to review it.

_____ _____

Printed Name Birthdate

_____ _____

Signature Date

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist and/or optometrist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. _____ and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

_____ _____

Patient (or person authorized to sign for patient) Date

_____ _____

Witness Date