Four Corners Eye Clinic
SPECIALIZING IN MEDICAL AND SURGICAL EYE CARE

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Welcome to Four Corners Eye Clinic!

We are happy you have chosen Four Corners Eye Clinic as your eye care provider. Please read the important notifications below, and sign the acknowledgement on the last page. This will help you become familiar with our practice policies.

OUR MISSION & YOUR FEEDBACK

We are constantly working to maintain and improve on our services to you. Four Corners Eye Clinic is committed to providing outstanding, quality, comprehensive eye care in a caring, professional environment. Shortly after your appointment, you will receive an invitation to participate in a brief on-line or telephone survey about your experience. You will receive an invitation by email, text and/or telephone. If you would prefer not to participate there will be an opportunity to opt-out and prevent future invitations. Also, our staff welcomes your feedback at any time during or after your visit to our office. Thank you for trusting our physicians and staff to care for your eye health and vision.

KEEPING INSURANCE INFORMATION UP TO DATE

It is the patient's responsibility to provide our office with accurate, up-to-date insurance information. If you do not provide our office with your current insurance information at the time of service, you will be responsible for payment at the time of service. Additionally, insurance companies have time limits on how long a provider can take to bill a claim. If a claim is not sent in a timely manner, it will be denied. If a claim is denied for untimely filing through no fault of our office, the charges will become the patient's responsibility.

INSURANCE REFERRALS / AUTHORIZATIONS

It is **always** the patient's responsibility to ensure that they have a valid referral/authorization for services rendered at each visit, if your Insurance Plan requires a referral/authorization. Should you arrive at the clinic WITHOUT a valid referral/authorization for that day's visit, you have the option of:

1) Contacting your insurance company to arrange for an immediate referral/authorization to be faxed to our office;
2) Being seen as a Self Pay visit and filing on your own to your insurance plan; or
3) Rescheduling your appointment. Unfortunately our clinic staff cannot contact your Insurance Carrier to obtain your referral/authorization for benefits.

MEDICAL EXAMINATIONS AND TREATMENT VS. VISION PLAN (ROUTINE) EXAMINATIONS

All doctors at our practice are medical doctors. Therefore, we bill medical insurances, not vision plans. The appointment is a "medical eye exam" not a "vision exam". When sending a claim to the patient's insurance company, our records will indicate that the patient was seen for a medical reason and has received a medical diagnosis. Our office generally will NOT send the claim under a "routine eye exam" diagnosis. Additionally, we cannot change the diagnosis on a claim in order to receive payment. All diagnoses must be documented in the patient's chart.

PLEASE CONTINUE TO THE BACK OF THIS FORM

INSURANCE ASSIGNMENT AND RELEASE; MEDICARE/MEDGAP AUTHORIZATION

I certify that I have insurance coverage with the company(ies) I provided and assign directly to the physician(s) at and Four Corners Eye Clinic, P.C. all insurance benefits, if any, otherwise payable to me for services rendered. The current physicians at Four Corners Eye Clinic include: Eric Meyer, M.D., Joshua Zastrocky, M.D., John Brach, M.D., Karyn Bourke, M.D. and David Bishop, M.D.. I understand that I am financially responsible for all charges whether or not they are paid by my insurance. I authorize the use of my signature on all insurance submissions.

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made to Four Corners Eye Clinic for any services furnished to me. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

REFRACTIONS (TEST FOR BEST CORRECTED VISION)

Refractions are not covered by Medicare or most medical insurance plans. Refraction fees are the responsibility of the patient. The fee is due and payable whether or not you receive a written glasses prescription. Refraction is a test for best corrected Visual Acuity and/or a Glasses Prescription. This test if often performed as a part of your annual eye exam. Vision changes can be a symptom of other conditions related to the eye beyond needing glasses. Therefore, we generally do not perform Refractions without an examination by one of our physicians. Fees may change from time to time, with or without notice. **Our current Refraction Fee is $40.00. Please inquire with our staff at the time of your service for our fee at that time.**

ARRIVAL TIMES & APPOINTMENT REMINDERS

Please arrive promptly for at your arrival time. When scheduling an appointment we will provide you with an arrival time at our office. The arrival time provides us with the opportunity to have you complete paperwork, have testing completed and when appropriate, your eyes dilated prior to seeing the physician. Patients who arrive later than their scheduled arrival time may be asked to reschedule.

We do our best to remind of your upcoming appointment and the arrival time. Our reminders will come to you through an automated phone call and/or email. Both the time we provide you for your appointment and when you receive a reminder message are the time we ask you to arrive at our office. Arriving on-time allows time to complete any paperwork, complete any diagnostic tests and be dilated when needed prior to seeing one of our physicians.

DILATION

Please note that your eyes may be dilated during your examination. Dilation of your pupils may blur your vision and make you sensitive to light for several hours after your examination. It is important to refrain from driving and performing precision work with tools when your vision is blurred from dilation. It is not possible to predict how long the effect of dilation will last or how much your vision will be affected. We recommend that you wear sunglasses when your eyes are dilated. Please ask the checkout staff for a complimentary disposable pair of sunglasses if you do not have yours with you. You may consider arranging for someone to drive you after your appointment.

PLEASE CONTINUE TO THE NEXT PAGE OF THIS FORM

PHARMACY PRESCRIPTIONS & REFILLS

You may be given a prescription for medication or medication refills in conjunction with your care. It is important that you check with your pharmacist and/or primary care physician regarding potential interactions with other medications you are currently taking. Our doctors also recommend that you check with www.prescribingreference.com to become aware of all potential risks/benefits and interactions for all medications. **For prescription refills, please contact your pharmacy first.** They will relay your request to us. We encourage our patients to plan ahead and notify your pharmacy at least 48 hours in advance when you require a prescription refill. If 48 hours passes after you contact your pharmacy, please call our office for further assistance.

ACCESSING YOUR HEALTH INFORMATION VIA WEB PORTAL

You have the opportunity to view certain health information from your visits to our office through a web portal. When you provide us with your email address, you will receive an email with instructions for accessing this information following your visit to our office. In the future, when there are new visits or certain health information is updated you will receive an email to notify you that there is new information available. Also, on your patient information form you may indicate that you would like to receive clinical reminders by email which will direct you to the web portal. If you do not provide us with your email address, you may request instructions from our office to access your web portal. If you have trouble accessing your information, our office can reset your log in information.

ADMINISTRATIVE FEES / MEDICAL RECORDS

There is a minimal clerical charge of $15 for any administrative form the office completes which is not already included in the fee for your medical exam. This includes and is not limited to the following: disability forms, vision forms, DMV vision forms, jury service, or supplemental insurance forms. Medical Records requests are prepared and fulfilled in accordance with Colorado law. Administrative fees may be charged in the preparation of medical records. Please ask for a copy of our current process for Medical Records Requests and Fees. In general, it takes approximately thirty (30) days to respond to a medical records request. Should we incur a bounced check from our bank, we will pass that on to you, as well as an administrative fee of $25.

CANCELLATION FEES

Kindly give 24-48 hours' notice if you are unable to keep your appointment, so that we may book another patient who needs our care in that time slot. A $25 cancellation fee may be applied to your account if we are not informed of your cancellation/need to reschedule within 24 hours of your scheduled appointment.

BILLING STATEMENT FEES & TIMELY PAYMENT DISCOUNTS

All collection costs, attorney's fees, and court costs are the responsibility of the patient. Should a Self-Pay service not be paid in full at the time of service, a $30 billing fee may be assessed to the patient's account. A $5.00 per month statement fee will be assessed on all accounts over 30 days past due, to the full extent allowed by law. From time-to-time Four Corners Eye Clinic may offer a discount to patients without insurance when their balance is paid on the date of service. Please inquire prior to leaving about how to receive a discount. Failure to pay on the date of service will result in the full billed charge being owed.

PLEASE CONTINUE TO THE BACK OF THIS FORM

CoPays, Deductibles, and Non-Covered Services

I acknowledge that I am financially responsible for copays, deductibles and non-covered services, and that those amounts will be collected at the time of service.

Billing and Collections

I acknowledge that Four Corners Eye Clinic is providing services in good faith and that it will be appropriately compensated in a timely manner. If necessary, the patient and/or guarantor will be held liable for any late fees, interest, collection fees, and/or reasonable attorneys' fees for the prosecution and/or collection of the patient amount owed. It is the patient's and/or guarantor's responsibility to provide Four Corners Eye Clinic with updated billing and insurance information on each and every visit.

I consent to be contacted by regular mail, by e-mail or by telephone (including a cell phone number), as well as the use of technology including auto-dialing and/or prerecorded messages in contacting me regarding any matter related to my account by Four Corners Eye Clinic or any entity to which Four Corners Eye Clinic assigns my account. I also consent to the use of any updated or additional contact information that I may provide.

Notice of Privacy Practices

I have received the Notice of Privacy Practices for Four Corners Eye Clinic. P.C.

By signing below, I acknowledge receipt of the above information, including general policies, financial policies and receipt of Notice of Privacy Practices.

_____ _____

Patient and/or Responsible Party Name (Please Print) Date of Birth

_____ _____

Patient and/or Responsible Party Signature Today's Date