Office Financial Policy

As part of our commitment to offer excellent medical and professional care to you and your family, we would like to present our office payment policy in order to minimize misunderstandings about fees. Our fees and methods of payments are comparable with other Ophthalmologists in the Pittsburgh area. We ask for payment at the time of service. This includes payment for the office visit and any tests that are performed. We commonly require payment at the time of check-in. **Any laboratory tests which require an outside lab company to perform will be billed separately by that company.**

As a courtesy, we will file all applicable office and hospital charges with your insurance carrier(s). By your signature below, you authorize and request that insurance payments be made directly to ***The Cataract & Laser Institute of PA***. **However, you are ultimately responsible for all charges**. We advise that you familiarize yourself with the benefits of your plan. Prior to any visit, testing, or procedure, we can assist you in determining your portion of the bill. This usually includes any un-met deductible, co-payment and co-insurance which are to be paid prior to the visit, testing, or procedure. We accept Cash, Checks, Master Card, Visa, or Discover.

After you have paid for your visit, you will receive an itemized statement. You can attach this copy to your insurance claim and send it to your carrier for processing if necessary.

We are providers for several HMO and PPO plans, in which case the above may not apply. Based on the signed Patient Insurance Verification form, you are responsible for your co-payment, deductible, out of pocket or other non-covered services as set by your insurance carrier. Co-payments, deductibles and out of pockets are collected at the time of service.

If your insurance carrier requires a referral number to receive services from our office, it is your responsibility to contact your Primary Care Physician to obtain the number prior to your office visit.

This policy is offered in an attempt to develop and sustain a continued professional and pleasant relationship. Your cooperation is greatly appreciated.

I have read and understand the above office financial policy.

Signature:_____ **Date:**_____

Printed Name: _____

Relationship to Patient:_____