SCOTT D. ALLEN MD AND ASSOCIATES PC
2300 E 30TH ST SUITE 105
FARMINGTON, NM 87401
(505) 327-0406

AUTHORIZATION & RELEASE

I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for medical insurance benefits or worker's compensation. I also hereby authorize payment of medical insurance benefits or worker's compensation benefits otherwise payable to me directly to the doctor. I understand that this authorization covers any insurance that is billed on my behalf.

To release your medical or billing information to anyone other than your spouse/guardian or other emergency contact please list their name and phone number.

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_____ _____

Signature of patient or guardian Date

HIPAA Notice of Privacy Practices

New Mexico Eye Clinic has provided to me a copy of the Notice of Privacy Practices. I understand that if I have any questions regarding the referenced document that I may speak with the Privacy Officer or other New Mexico Eye Clinic staff to have my questions and concerns answered. I also understand that I may request at any time a copy of this notice or updated notices.

_____ _____

Patient Signature (18 years or older) Date

REFRACTION CHARGES

As ophthalmologists, refractions are performed as a necessary part of an eye exam to determine the health of the eyes as well as how well the patient sees. **This test is necessary for the purpose of prescribing eyeglasses and we cannot provide you with an eyeglasses prescription without this part of the exam.** Medicare and most medical insurance plans consider this service as a routine exam and totally separate service and charge from the dilated eye exam and ***it will not be covered***. Unfortunately, you the patient will be responsible for this charge in addition to any other patient costs as defined by your medical insurance coverage. We provide a ***significant discount*** to you, the patient, if the refraction charge is paid at the time of your visit otherwise you will be responsible for the full billed amount if you want to be billed.

_____ _____

Signature of patient or guardian Date

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PATIENT FINANCIAL AGREEMENT

I have read the Patient Financial Policy and understand that regardless of insurance coverage I am responsible for all copays, coinsurance, deductible, refraction, non-covered services, or any other services denied by my medical insurance because of benefit or plan coverage limitations. *I agree to pay any patient responsible estimated amounts AT THE TIME OF MY VISIT with cash, credit card or check.*

I understand that unless previous arrangements have been made that I am expected to pay all estimated patient amounts at the time of the visit. I am prepared to pay for any and all of my expected patient payments today and understand they must also be paid at any future visits.

_____ _____
Patient/Responsible Party Signature **Date**

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ALL COPAYS ARE DUE AT CHECK IN. ANY COINSURANCE OR DEDUCTIBLE AMOUNTS ARE DUE AT CHECKOUT.

RED FLAGS RULING BY FTC: Effective May 1, 2009 through the "Red Flags" Ruling the Federal Trade Commission requires that anyone who provides credit of any kind have policies in place to avoid identity theft. The FTC ruling has determined that medical/healthcare providers fall under this ruling as it also includes medical identity theft. Effective immediately we must have a copy of government issued photo ID from the patient/responsible party to file to ANY insurance, accept a check or credit/debit card to pay for care provided in our office. We realize that many believe this a violation of their rights and we understand your concerns, however, to avoid monetary penalties that may be associated with noncompliance of this ruling it is necessary. You may find further information online at: www.ftc.gov/os/fedreg/2007/november/071109redflags.pdf.

MEDICAL INSURANCE COVERAGE: As a service to you, we will file your medical eye examination to your medical insurance carrier. **It is the patient's responsibility to provide our office with the most current insurance cards.** We will only file to medical insurance plans that we have ***current*** insurance cards on file. Your benefits for services provided and the amount you owe, however, is determined by your insurance. We strongly recommend contacting your insurance company to verify your coverage and benefits for a ***medical eye exam*** prior to your visit and document in writing your call to them. We will attempt to verify your eligibility and benefits with your insurance. Any questions you the patient have regarding your coverage, benefits, non-covered services, co-payments or co-insurance must be addressed with your medical insurance plan. **All copay, coinsurance, and deductible information provided by our office is ONLY an ESTIMATE and is subject to final report by your medical insurance plan *AND MUST BE PAID AT THE TIME OF THE VISIT***. Our doctors are not considered in network providers with every insurance. THE PATIENT IS RESPONSIBLE FOR ALL BILLED CHARGES FOR ANY PLAN WE ARE NOT CONTRACTED. As a courtesy we will file your claim to your insurance but will not be responsible for any follow up with them for payment. You may wish to discuss payment options before being seen with our billing staff.

SECONDARY INSURANCE: As with your primary medical insurance coverage, we are not contracted with all insurance plans. We will file to your secondary coverage only if we have a contract with them or if it is secondary to your standard Medicare plan. (We will not file to ANY secondary plan if you are covered by any Medicare Advantage/replacement plan.) **We will only file to secondary plans ONE TIME**. If the secondary plan does not pay within 30 days after the first submission by Medicare crossover or paper claim sent by our office the responsibility will be transferred to the patient. **If your secondary insurance does not cover all the coinsurance, deductible or copay from the primary insurance you will be required to pay any expected patient amounts due at the time of the visit.**

VISION INSURANCE: We do not file any charges to any vision insurance such as VSP, Davis, Spectra, etc. Our office will provide you with a statement that you may use to file with your vision plan if needed.

CASH PATIENTS: ***Patients with no insurance or that do not provide current insurance cards at check in are expected to pay for the visit in full at the time of service.*** Our office will make every effort to work with patients who have medical eye problems, regardless of ability to pay, to make sure you receive the appropriate care needed. If you need assistance, please ask to speak to the office manager to make arrangements.

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STATEMENT FEE: We will be happy to bill you but there will be an **additional $25.00 statement fee** charged to your account. A statement fee will also be added to the SECOND statement for any unexpected additional amounts owed by the patient after insurance pays and once a month until the balance is paid in full.

UNPAID BALANCES: Any patient balances left unpaid after you receive a final notice from our office will be turned over to the Credit Bureau of Farmington for collection purposes. We will make every effort to work with you on any unpaid balances due before proceeding to this step.

DILATED EXAMS: As part of your yearly complete eye exam it is necessary to dilate your eyes so that the doctor has a complete look of your eyes. Dilation results in sensitivity to light and inability to see well at close range or distance for a few hours. Our office will provide you with a pair of free disposable sunglasses. Patients should wear sunglasses, use caution walking and going up and down stairs. We recommend avoiding driving or operating dangerous machinery immediately after being dilated. We also recommend you have someone drive you home or wait until your eyes return to normal so that you can drive safely. (Note: Refractions for an eyeglasses prescription is NOT included in this part of the exam.)

ROUTINE EYE EXAMS: A routine eye exam is done for patients who do not have any eye problems but want an eye exam and these exams are typically not covered by your medical insurance and are never covered by Medicare. It is necessary to let us know if you are having vision changes, vision is blurry, have cataracts, pain in or around the eye, dry eyes, or if you have any medical conditions such as diabetes, high blood pressure, arthritis, etc. as these conditions and their treatments require a medical eye exam and not a routine exam and will usually be covered by your medical insurance.

NOTE: Our office will scan only the signature pages of the patient demographic form and PATIENT'S FINANCIAL and EXAM RESPONSIBILITIES and return to the patient the entire policy for your records. All original paperwork not kept by the patient will be shredded after scanning.