

EYE ASSOCIATES OF WASHINGTON, D.C., P.C.
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FINANCIAL POLICY

At Eye Associates of Washington, D.C., P.C, we are committed to providing you with the highest level of service and quality care. If you have medical insurance, it is your responsibility to provide our practice with your insurance information to help you receive your maximum allowable benefits. Ultimately, however, all financial liability rests with the patient. Please have your photo identification and current insurance information available at your visit to ensure that your claim can be processed promptly.

Insurance Companies and Non-Covered Services:

Our office participates with many major insurance companies.
It is a patient's/parent's/guardian's responsibility to:

- ✓ Be familiar with the benefits of your plan, including co-pays, co-insurance and deductibles.
- ✓ It is the patient's responsibility to find out from his/her insurance company whether or not the insurance company will cover the service being provided.
- ✓ Bring all of your current insurance cards to all visits
- ✓ Provide our practice with current information including address, phone numbers and employer
- ✓ In accordance with your insurance contract, you must be prepared to pay your co-pay and/or deductibles at each visit.

We accept cash, checks and all major credit cards for service.

- Evaluation and purchasing of contact lenses are frequently not covered by insurance companies, which our practice participates with. Full payment is due from the patient when ordering contact lenses.
- *Most insurance companies, including Medicare, do not cover a refraction.* Our office fee for refraction is **\$55.00**, and this fee is collected at the time of your visit in addition to any co-payments and/or deductibles.
- We provide medical, surgical and cosmetic ophthalmologic care to our patients and while we provide routine eye examinations -- when the patient has no medical complaints, we do not accept ANY vision plans or bill health insurances for these exams. You may submit a claim to your insurance to try and seek reimbursement for routine services. Our charges for examinations are available upon request.

****If you do not have a medical complaint you will be financially responsible for all charges at the time of service.****

Outstanding Balances:

We appreciate prompt payment in full for any outstanding balance. If your account is turned over to a collection agency, you agree to pay fees imposed by the collection agency in order to collect the overdue amount. Any check payments that do not clear the bank will be subject to a **\$25.00** returned check fee.

Read over ==>>>>

Referrals:

If you have a managed care plan that requires a referral to see a specialist, you *must* obtain a referral in order for your visit in our office to be covered under your medical insurance. If you do not have the valid referral and still wish to be seen, you will be asked to sign a waiver and pay for the visit prior to your examination. If you receive a prescription for glasses or contact lenses you will be charged **\$55.00** which is payable at the time of the visit.

Forms:

There is a charge for completing various forms, including DMV visions forms. Pre-payment is required for completing forms, or for extra written communication by the doctor.

Fees:

Below please find a list of common services and their respective fees:

Service	Charge	Payable
Refraction	\$55.00	At time of service
Rapid Viral Test	\$40.00	At time of service
DMV Vision Form	\$20.00	Upon acceptance of the form
Disability Forms/Letter from Doctor	\$40.00	Upon acceptance of form/request
Self-Pay Patients		At time of service
Non Covered Services		At time of service
Cosmetic Services (incl. Botox & Dermal Fillers) and surgery		At time of service & 2 weeks prior surgery
Premium Cataract Lenses		At least two week before surgery
Deductibles		At time of service
Medical Record Copying Fee	Variable	At the time of service

Minors/ Dependent Patients:

For all services rendered to minor/dependent patients, we will look to the adult for payments accompanying the patient and/or the parent or guardian with whom the child resides. In cases of separation or divorce, when presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply their name, address, phone number, date of birth and social security number. We request that you inform the subscriber that their insurance has been used.

Your signature indicates that you have read, understand and agree to the financial responsibilities policies and procedures of our office.

Signature of patient/guardian

Date

Printed name of patient Date