



# EYE ASSOCIATES

OF WASHINGTON DC

**PAUL T. GAVARIS, M.D.**  
**FRANK S. ASHBURN, JR., M.D.**  
**F. STROTHER ASHBURN, III, M.D.**

**MELANIE J. BUTTROSS, M.D.**  
**LAUREN Z. GAVARIS, M.D.**

OPHTHALMOLOGY | OCULOPLASTIC SURGERY | OPTHALMIC SURGERY | CORNEA & EXTERNAL EYE DISEASE | GLAUCOMA

## **FINANCIAL POLICY**

At Eye Associates of Washington, DC, 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. However, all financial liability rest 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 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 your responsibility to find out from your insurance company if the insurance company will cover the service provided.
- Please bring all your current insurance cards to all visits.
- Provide our practice with current information including address, phone numbers, email address 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. Full payment is due when contact lenses are ordered.
- Most insurance companies, including Medicare, do not cover a Refraction. Our office fee for a refraction is **\$65.00**. 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 also provide routine eye exams to our patients with no medical complaints, we do not accept ANY vision plans or bill health insurance for these routine exams. You may submit a claim to your insurance to try and seek reimbursement for routine services. Our charges 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 to collect the overdue amount. Any check payments that do not clear the bank will be subject to a **\$30.00** returned fee.

### **Referrals**

If you have a managed care plan that requires a referral to see a specialist, you **must** obtain a referral 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.

**Continued on the back**

### **Refractions**

If you receive a prescription for glasses or contact lenses you will be charged **\$65.00** if your insurance company does not cover it, which is payable at the time of the visit.

### **Forms**

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

### **Common Fees**

<b>SERVICE</b>	<b>CHARGE</b>	<b>PAYABLE</b>
Refraction	\$65.00	At time of service
Rapid Viral Test	\$50.00	At time of service
DMV Vision Form	\$30.00	Upon acceptance of form
Disability Form/Doctor Letter	\$40.00	Upon acceptance of letter
Self-Pay Patients		At time of service
Non-Covered Services		At time of service
Cosmetic Services (Botox®, Dermal fillers, Surgery)		At time of service/2 weeks prior to surgery
Premium Cataract Lenses		2 weeks before surgery
Deductibles		At time of service
Medical Records Copying fee	\$30.00	At time of service

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

**Signature of Patient** \_\_\_\_\_

**Date** \_\_\_\_\_

### **Minors and Dependent Patients**

For all services rendered to minors and dependent patients, we will look to the parent or guardian accompanying the patient. In case 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.

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

**Signature of Parent/Guardian** \_\_\_\_\_

**Date** \_\_\_\_\_