Advanced Valley Eye Associates
Robert B. Miller, M.D.

2035 Lyndell Terrace, Suite100
Davis, CA 95616
Phone:530-757-6000
Fax: 530-231-5873
www.lasikbymiller.com

PRACTICE POLICIES & FINANCIAL AGREEMENT

Thank you for choosing us as your health care provider. We are committed to making your treatment a success!

Patient Information Form – ***This must be completed before seeing the doctor.***

If we need to contact you or a member of your family with a lab result, medication questions or if you unexpectedly have a problem requiring emergent transfer or a ride home, we must have a contact name and telephone number. We are required by law to collect this information, and can NOT see you if this information is not provided.

Financial Policy – ***We are happy to bill your insurance carrier directly.***

We will be happy to bill your insurance carrier at the time of visit, if you provide us a copy of your cards, and we can determine eligibility at the time of your visit.

If you do not provide us with your insurance information, you will need to pay for the office visit in full. If the insurance card and all necessary information needed to bill the claim is provided to us within 24 hours of your visit, we will reimburse and wait for the insurance company's payment.

Please understand that all health insurance plans represent a contract between you and your insurance company. Depending on your individual insurance coverage, your carrier may cover all, some, or none of the services rendered to you at Advanced Valley Eye Associates.

Regardless of the coverage of your insurance, you remain responsible for settling the charges. Therefore, it is your responsibility to see that the insurance carrier makes prompt payment and to handle any disputes or questions that may arise.

If AVEA is contracted with your insurance company, we will accept their "approved fee" as payment in full, and you will not be responsible for any additional balance, other than your deductibles and co-pay.

Co-payments for insurance plans are due prior to treatment.
If you do not make your co-pay at the time of visit, a service charge of $10.00 will be assessed to your account.

Please understand that Insurance/Medicare may not cover all the services you receive. If your insurance carrier does not cover a service, you are personally responsible for payment.

If we anticipate any services might NOT be medically covered, we will make you aware in advance of the service, and ask you to sign an Advanced Beneficiary Notice (required by law with Medicare recipients).

Other ways to pay:
If you do not have insurance, we offer a discounted rate for payment of services at the time of care. We accept cash, credit cards and checks. These will be held at the front desk until you check out, and will give you a copy of your fee sheet for tax purposes.

Cancelled or missed appointments:
We require a minimum of *24 hours notice* for canceling appointments. If an appointment is not cancelled within this time, there will be a fee of $25.00. For each additional appointment missed or not canceled 24 hours prior to the appointment time, additional fees will be applied. To avoid a fee, simply call us to cancel (day or night) at 530.757.6000.

Medical records transfer policy:
We will gladly forward medical records with a signed HIPAA compliant release on file. Please keep in mind that the records *can take up to 15 days to complete*. In rare instances, there will be a fee assessed for copying large files of records.

Prescription Policy:
If you have a current prescription and no change in the medication dosage or pharmacy have been made, you can contact your acting pharmacy directly to put in a refill request. They will notify us by fax on our automated system. Please allow 48-72 hours for this transaction to occur as your provider may not be available at the time of your request.

Form Completion Request Policy:
We will gladly complete your forms (DMV, etc.), however due to the volume of requests that we receive, please allow up to 7 business days for your form to be reviewed and completed.

For any questions regarding payment options or financial responsibilities, please speak to one of our helpful staff! We are happy to work with you.

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Acknowledgement of AVEA's Practice Policy and Financial Agreement

I have read, understand, and agree to the payment arrangements described in Advanced Valley Eye Associate's Practice Policy and Financial Agreement.

If I owe personal balances, I will promptly pay them and bring them current. Failure on my part to pay my personal financial obligations to Advanced Valley Eye Associates could result in my account balances being turned over to collections. I agree to pay any collections costs incurred by the clinic.

I authorize the release of any information my insurance company may need to process my claim, and I authorize my insurance company to issue payment directly to Advanced Valley Eye Associates.

_____ _____

Patient Signature (or responsible party for patient) Date

_____

Printed Name

_____

Relationship to patient (if applicable)