ALL EYE CARE, P.A.
VISION, MEDICAL & SURGERY

RAJIV RUGWANI, M.D.
Eye Specialist & Eye Surgeon

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ADVISEMENT OF PATIENT RESPONSIBILITY /POLICY

For our office to file a claim with your insurance we must have a copy of your primary and secondary (if applicable} insurance cards to be placed in your file, along with current picture identification. If the primary insurance requires a referral from your PCP to see a specialist (Dr. Rugwani) we must have the referral in our office prior to your visit. **Patient is responsible to obtain a referral from their PCP.** If we are unable to confirm valid insurance coverage, the entire fee will be due and payable at the time services are rendered.

It is the policy of this office that any co-pay, deductible and/or coinsurance amounts identified by insurance as patient responsibility will be collected at the time services are rendered, unless prior arrangements have been made through our business office. Any patient responsibility for cataract surgery must be paid prior to surgery date. All Eye Care, PA/Dr. Rugwani does NOT offer payment plans.

PAYMENT POLICY FOR REFRACTION

Refraction is a separate test that determines the power needed for your eyeglass prescription. A series of test lenses are carefully presented to determine which power provides the clearest and sharpest vision for you. Unfortunately, Medicare and most medical insurance companies DO NOT cover this expense as part of the examination and as such **we will collect our refraction fee of $25 from the patient at time of service.**

INSURANCE ASSIGNENT/RELEASE OF INFORMATION AND PATIENT RESPONSIBILITY

I hereby authorize All Eye Care, P.A. to release any information concerning my care for the purpose of filing claims to: federal, state, city or town governmental agencies, third party payers of all categories, doctors and hospitals, in accordance with HIPPA (Health Insurance Portability and Accountability Act) regulations.

The person signing below, whether signing as a patient, or legal representative of the patient, agrees that he/she has read and understands the above terms and conditions and individually obligates himself /herself to pay All Eye Care, P.A. for services rendered. The person signing below understands that a quote of benefits from this office is **NOT A GUARANTEE OF PAYMENT** and actual insurance payments will be determined by patient's policy at the time a claim is processed. In the event insurance does not pay the bill within 90 days he/she will be responsible for payment of the balance in full. Should the account be referred to an attorney for collection, the person signing below will be responsible for all attorney's fees and collection expenses.

Relationship to patient: Self Spouse Parent Other_____
(PLEASE CIRCLE ONE)

_____ _____ _____
Printed Name Signature Date