MILAUSKAS
EYE INSTITUTE
The Desert's Leader in Eye Care

NOTICE OF BILLING PRACTICES:

THIS NOTICE DESCRIBES OUR BILLING PRACTICES, PLEASE REVIEW IT CAREFULLY.

At Milauskas Eye Institute, you can expect to receive medical services in a professional and caring manner. We are committed to providing you with the highest level of service and quality care. In return, it is your responsibility to provide your insurance information. Please have your photo identification and current insurance information available at your visit to ensure that your claim can be processed promptly.

1. APPOINTMENTS: We request that you keep scheduled appointments and arrive that the appointed time. If you are unable to keep your appointment, please give at least 48 hours notice. Cancellations of less than 24 hours prior to your appointment, or a No-Show for your appointment, will result in a $25 fee per patient.

2. CO-PAYS: According to your insurance contract, you are obligated to pay any co-pay due at the time of service. IF you are unable to pay the co-pay at the time of service, we retain the right to cancel or reschedule your appointment to a time when you are prepared to pay your co-pay. Furthermore, if your appointment is kept without payment of the co-pay at the time of service, we retain the right to levy an administrative charge of $10 to your account in order to defray the cost of securing the co-pay.

3. PRESCRIPTION REFILLS/FORMS: Please request any prescription refills and present any forms that need to be completed at the start of your examination. At that time, we have full access to your complete record and can fulfill your request. When we have to provide these services at another time, there is a $25 fee to cover the time and effort required to retrieve and review your medical record.

4. REFERRALS: If your insurance plan requires a referral, the referral must be presented before seeing a physician. If you do not have the required referral, we reserve the right to reschedule your appointment or you will have to be willing to be responsible for the entire cost of the examination.

5. RETURNED CHECKS: Any payment made by check that does not clear our bank account will result in a fee for insufficient funds. Our fee for insufficient funds is $25 and will be added to your account for each bounced check.

6. OTHER INSURANCE: I understand that Milauskas Eye Institute participates with multiple insurance plans and that not all Doctors in the Practice participate with all plans or products within the plans. I understand that it is my responsibility to verify with my insurance carrier that my physician currently participates with my plan. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Milauskas Eye Institute if I belong to a plan with which Milauskas Eye Institute does not participate.

7. NON-COVERED SERVICES: I understand that Milauskas Eye Institute contracts with health care service plans related only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care plan service plan furnishes to the patient (i.e. refraction) and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Milauskas Eye Institute to obtain necessary health care service plan authorizations.

MILAUSKAS
EYE INSTITUTE
The Desert's Leader in Eye Care

8. FINANCIAL AGREEMENT: I agree that in return for the services provided to me by Milauskas Eye Institute, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Milauskas Eye Institute for payment. I understand and agree that if my account is delinquent, I may be charged interest of 1.5% (one and one-half percent) per month, 18% (eighteen percent) per year. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees of 33.3% (thirty-three and one third percent) of the balance due, whether or not suit is filed. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Milauskas Eye Institute. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Milauskas Eye Institute. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Rev. 06/2019

The physicians and staff at Milauskas Eye Institute appreciate your confidence in allowing us to participate in your eye care.

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

PATIENT'S NAME: _____

PATIENT'S DATE OF BIRTH: _____

PATIENT/GUARDIAN SIGNATURE: _____

WITNESS SIGNATURE: _____

Date_____ Time_____