

**Financial Responsibility Policy for  
Charles Shidlofsky, O.D., P.A.**

This document is provided to you so that you will understand both your responsibility as the patient, and our responsibility as the provider in regards to your insurance coverage.

We accept assignment to many insurance companies, which means, we accept a negotiated rate as a provider. As a courtesy to our patients, we do file the initial insurance claims for those companies for which we have agreed to accept assignment. All insurance information must be presented at the time of your examination. We cannot accept any changes to this information past the date of service. After that time, we can provide any information you need so that you can file the claim on your own for reimbursement.

Some health plans require that we inform you in advance that they may deny payment for “services not covered”, “services not deemed by the health plan to be reasonable and customary or medically necessary”, “services not covered for this type of provider”, “diagnosis not appropriate for this type of procedure” and “procedure has been deemed to be experimental”. Charles Shidlofsky, O.D., P.A. renders only services that, in their professional judgment, are necessary to provide quality health care for you.

In order for us to collect from you for our services when payment is denied by your health plan, your health plan requires that you sign the following agreement.

Agreement: I have been notified by Charles Shidlofsky, O.D., P.A. that payment may be denied for the reasons above, or that have been specifically requested by me, the patient.

**If payment is denied, I agree to be personally and fully responsible for payment within six months.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Your Health Plan Coverage**

Charles Shidlofsky O.D., P.A. is committed to providing you with the best possible care and helping you to receive maximum benefits under your health plan. In order to achieve these goals, we need your assistance.

1. It is your responsibility to know if a referral is necessary for your visit.
2. Co-payments are due at the time of the visit. We are considered “Specialty Co-payments”.
3. A valid, current insurance card must be presented at each office visit.
4. If the service is not a covered benefit, or if your health plans tells us you are not covered, **payment in full for all services rendered are due on date of service.** If your insurance subsequently makes payment, any over payments will be refunded to you.

**Regarding Your Health Plan**

1. Your insurance is a contract **between you, your employer and the insurance company.** We are not party to that contract. While we may have an agreement with many of the health plans to provide services, **any questions regarding coverage must be resolved by you with the insurance company.**
2. **Not all services are a covered benefit in all contracts.** Some health plans select certain services that they will not cover.

**By signing below, I acknowledge that I have read this information and understand completely.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

