Financial Responsibility Policy for Neuro-Developmental Vision Evaluations/TBI patients
Charles Shidlofsky, O.D., P.A. and affiliate organizations

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.

Neuro-Developmental Vision evaluations and TBI evaluations are specialty examinations that contain several components. Commercial insurance companies cover only the eye health evaluation, review of systems and basic case history portions of these evaluations. These examinations have higher complexity and time components which include but are not limited to: reviewing and interpreting an extended case history, neuro-developmental vision testing or TBI vision testing and creating reports to the referring doctor, therapist or teacher. These specialty components are not covered by insurance, have no corresponding CPT code and therefore will not be billed to your insurance company. The non-covered portion is due at the time of service.

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. and affiliates 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. and affiliates that payment may be denied for the reasons above, or that have been specifically requested by me, the patient.

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 in a timely manner.
5. **Children of Divorced Parents:** Responsibility for payment for treatment of minor children, whose parents are divorced, rests with the parent who seeks treatment. Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of Charles Shidlofsky, O.D., P.A. or its affiliates.

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. In addition, If payment is denied, I agree to be personally and fully responsible for payment within three months (90 days). Any balance deemed patient responsibility and which remains unpaid after three months of invoices (90 days) will begin various collections activities including, but not limited by submitting the past due account to a collection agency and adding collection fees.

Signature____ **Date**_________________________