

Child Eye Care Associates, LLC Policies and Procedures

Our goal is to provide the best possible medical care in a friendly and efficient environment. Policies and procedures are put in place to allow us to follow the laws we are required to adhere to and to provide you/your child with the best possible ophthalmic care.

We ask that you initial each policy in the space provided. Every patient must have a signed copy of our policies and procedures in their chart before they are seen for their initial visit.

Financial Policy

Insurance Cards and Photo I.D.: We are pleased to accept most medical insurance plans. A current, valid insurance card and photo I.D. must be presented at every visit. We will not be able to submit claims to your insurance company without a card and you may be asked to pay in full for the office visit. Child Eye Care Associates, LLC will submit a claim to the insurance carrier for which you have provided billing information. If claims for service provided to your or your child are denied by the insurance company or Medicare, you will be responsible for payment. By signing this page you authorize Child Eye Care Associates, LLC to release any necessary medical information about you or your child to your insurance carrier to further the processing of your medical insurance claim.

Initial: _____

Vision Plans: We are not contracted with any vision plans and cannot file claims with vision plans.

Initial: _____

Referrals: You are responsible for obtaining the referral from your primary care physician. If your insurance company requires a referral and Child Eye Care Associates, LLC has not received one, you will be responsible for payment. If you have questions about this, please contact your insurance company for plan details.

Initial: _____

Fees: All self-payment amounts, co-payments, deductibles and co-insurance fees will be collected at the time of services. We accept cash, check, MC, Visa and Discover.

Any other costs not reimbursed in full by your insurance carrier, will be billed to you and payment is expected within 30 days of receipt of an account statement. Accounts not settled within 90 days shall be considered delinquent and charged with a 1.5% finance fee.

We understand that temporary financial problems may affect timely payment of your account. If such a situation arises please contact our billing representative at (503)635-4436 x103 in a timely manner, to set up payment arrangements.

Initial: _____

Cancellation and rescheduling policy

Appointment Times: Our physicians and staff will make every effort to keep our schedule running on time for you with the exception of unavoidable delays beyond our control. Appointments for new patients may last up to 2 hours; please plan your time accordingly. You may be asked to reschedule if you arrive more than 15 minutes after a scheduled appointment time.

Initial: _____

Appointment cancellation: Please give a minimum of 24 hours' notice to cancel or change an appointment. Not showing for your appointment and not cancelling in advance denies another patient the opportunity to have an appointment at that time. You are responsible for keeping your appointment date and time regardless of current reminder methods. **Appointments cancelled without 24 hour notice will be charged \$35.00.**

After 3 missed appointments, Child Eye Care Associates, LLC reserves the right not to schedule any further appointments for your child.

Initial: _____

Other office policies and etiquette

Children & Contact Lenses: If your child is a contact lens wearer, please bring the prescription details with you to the visit and have your child wear their contacts. Ideally, contacts should be worn for at least 4 hours before your child's appointment so that we may accurately assess the lens fit and any prescription changes.

Food and Drink: Food and drink are NOT permitted in the office waiting room or examination rooms. Please leave your food and drink in the car or dispense with it before you check in for your appointment. The goal is a *clean and healthy* environment for everyone. We respectfully request that adults as well as children comply with this policy.

Changing Diapers: We do not have changing facilities in our office but changing stations are located in the restrooms which are on the same floor as our office. In order to provide a clean, healthy and comfortable environment for all our patients, we ask that you do not change your child in our examination rooms.

Cell Phone Use: Please limit use to essential conversations and turn your phone to silent during the length of your visit.

I acknowledge I have been made aware of these policies and procedures.

Signature of patient, parent or legal guardian

Date

Patient Name (please print)