

Strom Eye Center
Billing and Insurance Information
(PLEASE READ CAREFULLY, THIS FORM MUST BE SIGNED)

1.

In order to make our care more efficient, we will need the following information presented to our receptionist when you visit our office. We require you to present your insurance card and photo ID. We will not file insurance without the presentation of your cards. If you do not have your cards, the visit will not be billed to your insurance company and you will be expected to pay for the visit that day of service. The receptionist also will require you to fill out paperwork at the time of your visit. This is to benefit you as the patient and our office so that our records are always up to date and your insurance company can pay the claims in a timely fashion.

2.

You understand that Dr. Strom is a specialist and sometimes, beyond our control, patients will need the attention of the doctor longer than expected. We always strive to book appointments as accurately as possible to the patients needs. However, sometimes you may experience a wait. Please understand that the doctor tries to allow the time needed to properly care for you as a patient.

3.

As a patient you may be recommended to have lab work, x-rays, MRI's or surgery. We leave the responsibility to the patient that you provide us with the facilities that participate with your insurance company. Failure to do so may result in us using the facility of our choice. You may receive a bill from the facility providing the service.

4.

As a patient you give the permission and consent for the doctor to obtain and release medical records. (Due to HIPAA, additional paperwork is required.) Our office requires a 24 hour notice to process the request for medical records to be faxed and /or copied. There may be a charge for the release of copied records.

5.

If you have insurance our office will file to your insurance as a courtesy. We suggest that you call your insurance company and confirm that Dr. Strom participates with your insurance. Although we file to your medical insurance on your behalf, medical insurance is ultimately a contract between you and your insurance company. If there is a denial from your insurance because we do not participate with your insurance or if there is not a proper authorization required by your insurance company, the bill will be your responsibility. If it is necessary to turn your account into collections you will be charged the greater of \$50.00 or 30% of the unpaid balance (Subject to change without notification).

6.

All Co-payments, Coinsurance, Deductibles, Refraction Fee, and Contact Lens Fitting Fees are due at time of service. We accept cash, check, Master Card and VISA as payment for services rendered. We have a \$50.00 return check fee for each check in the event your bank returns a personal check (Subject to change without notification). You understand that your insurance may leave a balance as patient responsibility, if this should happen payment is due to The Strom Eye Center for services rendered.

7.

You understand that a specified time has been given to you for your appointment. You need to arrive 15 minutes prior to your scheduled appointment to update any paperwork that might be required. If you do not arrive as requested you may be required to reschedule for the courtesy of other patients. If you are a NO SHOW, CANCEL less than 24 hours prior to your scheduled appointment or are more than 10 minutes late, a \$50.00 fee will be billed to you.

8.

Our office is required by law to maintain the privacy of your protected health information and to provide you with a notice about legal duties and privacy practices regarding the information we collect and maintain about you. A copy of our Notice of Privacy Practices has been provided to you at the time of your visit. In that Notice we described, among other things, how medical information about you may be used and disclosed and how you can get access to this information.

By your signature on this form, you are acknowledging that you have read and agree to the terms defined above. A copy of this signed acknowledgement will be maintained in your medical chart at the Strom Eye Center.

SIGN: _____ DATE: _____

PRINT NAME: _____