BRANDYWINE
EYE CENTER
2500 Grubb Road Suite 234
Wilmington, DE 19810
brandywineeye.com

Authorization for Release of Information

Many of our patients allow people such as their spouse, parents, children, or others to call and request medical or billing information. Under the requirements of Health Insurance Portability and Accountability Act, commonly known as HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical and/or billing information released to anyone, you must include their names on this form and sign below.

- ☐ I authorize Brandywine Eye Center/Shyu Eye Care LLC to release my medical, billing and/or appointment information to the following individual(s):
- ☐ I decline

Name	Phone Number	Relationship

1. I understand that I have the right to revoke the authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.
2. You have the right to revoke this content in writing.
3. This authorization will expire five (5) years from the date this authorization is signed.

Signature: _____
Printed Name:_____
Date: _____

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Insurance Authorizations

Medicare

If you have some form of Medicare, we need your signature on the following statement so that we may submit your charge to your insurance company. I request that payment of authorized Medicare/Medigap benefits be made to me or on my behalf to Brandywine Eye Center/Shyu Eye Care LLC, for any services furnished to me by that supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

Signature: _____ Date:_____

Commercial Insurance

If you have commercial insurance, we need your signature on the following statement so that we may submit your charge to your insurance company. I authorize any holder of medical information about me to release this information to my insurance company, its intermediates or carriers, to my attorney, or to another physician's office. I hereby authorize direct payment of medical and/or surgical benefits to include major medical benefits to which I am entitled, private insurance, and other health plans, to Brandywine Eye Center/Shyu Eye Care LLC. I understand that, as these services were performed for me, I am financially responsible for all charges, whether paid by insurance.

I understand that a referral letter or an authorized referral number may be required for certain HMO or commercial insurances prior to scheduling this visit in order to ensure that it is a covered benefit. This required referral letter and/or authorization is to be obtained and delivered to the Provider's office within five (5) business days of the date of service; it should be backdated to the original date of service as noted above. I also understand and agree that if I do not obtain the required letter and/or authorization within five (5) business days of the date of service and deliver it to the Provider's office, then I will be responsible for payment of charges and will be billed directly. The HMO will not be responsible for any charges connected with this unauthorized visit.

Signature: _____ Date: _____

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Refraction Policy

What is refraction?

- A refraction is the part of your eye exam used to determine if you need glasses. It is necessary to write a prescription

Is this a covered service?

- Most medical insurance plans, including Medicare, **do not cover** refraction, even when it is medically necessary (such as cataract evaluations). It is considered a **non-covered service.**
- Centers for Medicare and Medicaid Services (CMS) have classified refraction (CPT 92015) as a service that is **not payable by insurance.**

How much is refraction?

- Our office fee for a refraction is **$65.00**, and this fee is collected at the time of service.

By signing below I acknowledge that I will be responsible for the cost of refraction if the procedure is not covered by my insurance.

Signature: _____ Date: _____

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Statement of Patient Responsibility

Your signature below forms a binding agreement between Brandywine Eye Center/Shyu Eye Care LLC ("BEC"), and the patient who is receiving medical services or the Responsible Party. The "Responsible Party" is the individual who is financially responsible for payment of medical bills. All charges for services rendered are due and payable at the time of service.

- Medical Insurance: We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible for any costs your insurance company refuses to pay for any reason. The Responsible Party must:
    - Pay any required copay at the time of the visit; and
    - Pay any additional amount owing within 30 days of receiving a statement from our office (when an electronic remittance advice is received, any amount you need to pay will be billed to the Responsible Party).
- Returned Check Policy: If a payment is made by check, and the check is returned for any reason the Responsible Party will be responsible for the original check amount and an additional **$40.00 returned check service charge**. A letter will be sent by BEC to the Responsible Party with notification of the returned check. If a response is not received by BEC within 30 days from the letter date, the account may be turned over to our collection agency and a collection fee will be added to the outstanding balance.
- Non-Payment on Account: Should collection proceedings or other legal action become necessary to collect an overdue account, the Responsible Party understands that BEC has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Signature: _____ Date: _____
Responsible Party Name (if applicable): _____
Responsible Party Signature: _____

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No Show/Cancellation Fee

- If a patient does not show up or cancels an appointment in less than 24 hours, Brandywine Eye Center charges a "No-Show" fee of **$100**
- If a patient does not show up or cancels a surgery or procedure in less than 2 business days, Brandywine Eye Center charges a "No-Show" fee of **$500**
- Brandywine Eye Center charges any forms that need to be filled out outside of the visit including DMV, disability, or FMLA paperwork of **$20**
- This policy applies to new and established patients and will be charged directly to the patient/guarantor, not to the patient's insurance
- All No-Show fees must be paid prior to the next appointment in order to be seen
- Brandywine Eye Center reserves the right to terminate the doctor-patient relationship of established patients due to no-shows

Name: _____
Signature: _____
Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

- I have read and understood the Notice of Privacy Practices.
- I understand that I may receive a paper or electronic copy of Brandywine Eye Center/Shyu Eye Care LLC Notice of Privacy Practices.

Name: _____
Signature: _____
Date: _____