COASTAL EYE CENTER
Paul Paré, MD, FACS
David Jones, MD, PhD

1000 SE Federal Hwy, Suite 200
Stuart FL 34994
Office 772-283-8444

Patient name:

Account:

Billing and Insurance Policy

To enable us to best treat you, we would like to provide you with our billing and insurance policies as they relate to you. **Please read and initial each paragraph.**

We recommend you have a refraction annually. **This is the test to determine whether you need a new prescription for eyeglasses, in order to obtain your best vision.** This is a necessary part of a thorough eye exam and is not covered by any insurance. This is the not same as dilation. There is a **$60.00** charge which will be paid at the time of the visit. **NOTE: By initialing you agree to a refraction at today's visit.**

Initials: _____

Our policy requires you to present current insurance cards at every visit. Every effort is made to verify insurance coverage before services can be rendered. Verification of insurance coverage is not a guarantee of payment by your insurance company. If we are unable to verify your coverage and benefits, you may be required to pay in full for your exam. However, if your insurance company does reimburse for services, we will refund you for the amount overpaid. If your insurance does not pay us in a reasonable time frame (45-60 days), the balance will automatically be transferred to the patient's responsibility. You are responsible for any co-pays, deductibles and coninsurance.

Initials: _____

As mandated by the federal government, all insurance companies including Medicare require that you, the patient, pay your co-pay and deductible as part of your contract with your insurance company. Failure to do so is violation of your contract and against the law. Because of this, we cannot waive co-pays and deductibles. **We require you pay your co-pay/deductible/co-insurance at the time of visit.**

Initials: _____

I understand and acknowledge that I am personally responsible to pay in full for services that my health insurer will not cover due to non-payment of my health insurance premiums. Any returned checks will result in an additional $30.00 fee.

Initials: _____

We will call/text/email to confirm your appointment at least 48 hours ahead of time. Failure to cancel your appointment 24 hours ahead of time or failure to show for your scheduled appointment will result in a $40.00 charge.

Initials: _____

We now offer a dilation reversal drop called Ryzumvi. Ryzumvi starts to work within 30 minutes, with most patients experiencing full dilation reversal within 60-90 minutes of use. Ryzumvi is an additional $20 charge that is not covered by your insurance. This is optional.

Initials:_____

Thank you for your cooperation and understanding.

_____ _____

Patient Signature Date