Stuart R. Winthrop, M.D.

515 E. Micheltorena St., Santa Barbara, CA 93103
Office: (805) 963-4272 LASIK Line: (805) 730-9111

PAYMENT & BILLING DISCLOSURE AND AGREEMENT

We will bill your insurance for you **if we have the complete information at the time of your visit.** If we do not have the necessary information, and/or Dr. Winthrop is not a contracted provider, we will ask that you make a full payment at the time services are rendered. If you provide the necessary information within 15 days, we will bill your insurance, and when payment is received, a refund check will be issued. Please be assured that we protect your information in accordance with HIPPA Federal law.

- **$60.00 Refraction charges are due at the time of service.** This is not a billable event to *most* insurance companies; therefore, we ask for this payment at the time of service. If you know your insurance covers this expense, we will bill it, and when payment is received, a refund will be sent to you.
- **Co-payments are due at the time of service.**
- **Dr. Winthrop welcomes Medicare patients. However, he does not accept Medicare assignment.** This means you'll be responsible for 20% of what Medicare allows, and any non-covered services, as well as your annual deductible. If you have a Medicare supplemental insurance, please inform us at the time of service, and we will bill the insurer for 20% of the Medicare allowable charge.
- It is the responsibility of the patient to be **informed of the exclusions and inclusions of their insurance policy**, including, but not limited to co-pay and deductible amounts.
- If you do not have proof of insurance**, by signing this form you understand and agree that you are fully responsible for complete payment of medical fees for services provided.**
- **Dr. Winthrop is not contracted with any HMO plans or Vision Plans**. If you have either kind of insurance stated above, and you choose to see Dr. Winthrop, you are expected to pay for this visit, in full, at the time of service.
- **If Dr. Winthrop is not a contracted provider on the panel of your insurance plan,** he is not under any obligation to accept the contracted amounts as payment in full. It is your responsibility to pay for the services rendered at the time of your appointment.
- If you need to cancel or reschedule an appointment, please call at least 24 hours in advance. Missed appointments without the required advance notice may be billed at $60.

PATIENT SIGNATURE
With my signature below, I acknowledge that I have read and accept all policies as described in this document.

Signature_____Date_____

PARENT OR LEGAL GUARDIAN SIGNATURE
As parent or legal guardian of patient, I agree to pay for all office charges at the time of service and all outpatient charges within thirty (30) days from the time they are provided. I understand that this office bills insurance as a courtesy and that payment of all charges is my responsibility.

Signature_____Date_____
(Parent or Legal Guardian)

Please Print Name_____

If you would like a copy of this sheet, please inform our office staff. Thank you.