Stuart R. Winthrop, M.D.

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 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.
- 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.
- **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.
- **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.
- **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.
- **$75.00 Refraction charge is due at the time of service.**
  This is not a billable event for most insurance companies; therefore, we ask for this payment at the time of service. If you have a supplemental eye care policy **in addition** to your main insurance (e.g. Vision Service Plan, or Medical Eye Services) they may cover the refraction, and you can make a claim on your own in this case as we are not member-providers for these insurances. We will be happy to provide you with a copy of your bill.
- **Co-payments are due at the time of service.**
- **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.
- **Missed appointments without the required advance notice may be billed at $60.** If you need to cancel or reschedule an appointment, please call at least 24 hours in advance.
- **CUSTOMER PRICING NOTICE**
  There is a 3% service fee to cover the rising cost of credit card acceptance that we pay when credit cards are used. This fee is not more than the cost of accepting cards. There is no fee for debit cards.

PATIENT SIGNATURE

With my signature below, I acknowledge that I have read, and I 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 (Parent or Legal Guardian) _____Date_____

Please Print Name_____

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