Treviño Eye Clinic & Optical

Administrative & Financial Policies

PERSONAL INFORMATION

Every patient is responsible for updating their personal information such as, name, address, phone, and insurance on an annual basis.

PAYMENTS

All patients are responsible for **FULL PAYMENT** at the time of service. This includes copay(s), deductibles, and/or refraction fees. We accept cash, checks, and major credit cards—Discover, Master Card, Visa, and American Express. **Post-dated checks are NOT accepted.**

ACCOUNT BALANCES AND CREDITS

Any pending or **previous balances** including optical and/or contact lens balances, **must be paid prior to any service rendered the day of the appointment.** All balances must also be paid prior to pick-up of glasses and/or contact lenses. Patients are notified of pending balances via statements. The patient has 60 days to complete payment of any pending balances. Any balance 60 days or more overdue, will be sent to a collection agency.

Credits must be approved by the billing director for validation before being issued to the patient. Credits on accounts are valid for 12 months. If a credit is issued as a check, checks may be picked-up by authorized individuals or can be sent via mail to the mailing address on file. Credits can also be returned to a bank account via debit card. Process may take 3 to 5 business days for a debit card transaction to be posted onto the bank account.

PATIENTS WITH INSURANCE

Although we bill your insurance company, you are financially responsible for all services rendered. If payment has not been received within sixty (60) days of billing your insurance carrier(s), we will contact you for assistance. Should your health plan deny coverage for any reason, **you will be responsible for payment** in full within thirty (30) days of your billing statement unless other arrangements have been made.

PRIVATE INSURANCE

Insurance is a contract between you and your insurance company. This office will file insurance claims as a courtesy to our patients. We cannot become involved in disputes between you and your insurance company regarding deductibles, co-payments, etc. other than to supply factual information as necessary. **You are responsible for the timely payment of your account**. If you have a co-pay or deductible, be prepared to pay it at the time of your visit/service.

Texas Medicaid, QMB

QMB Medicaid has limited benefits. **Anything that is not covered by Medicare will not be covered by QMB**. The refraction ($30.00 charge) is a non-covered Medicaid service, thus the **patient is responsible for payment at the time of service.**

TEXAS MEDICAID

We are MEDICAID providers for the State of Texas, but we do **require that you bring your card with you at every visit to demonstrate your monthly coverage**. Please also be sure to provide a picture I.D. at the time of your visit.

PATIENTS WITHOUT INSURANCE

Our fees cannot always be determined in advance, since they depend on services rendered**. FULL-PAYMENT IS DUE AT THE TIME OF SERVICE.** We accept cash, checks, and major credit cards—Discover, Master Card, Visa, and American Express.

REFRACTION

Most insurance companies do not reimburse the practice for refraction services which is a necessary part of the eye exam in which the prescription is generated. **The cost to you when this service is given is $30.00 payable at the time of service.**

APPOINTMENTS

The maximum number of family members permitted on the same day with the same Doctor is 2. A family of 2 can be scheduled on the same day if the patient agrees to set the third appointment with a different Doctor.

As a courtesy to our patients, a fifteen minute grace period is allowed for arrivals after the appointment time. However, **any late arrivals may result in the need to reschedule the appointment.** We greatly appreciate a notice of late arrival.

CANCELLATIONS

Any appointment cancellation requires a 24 hour notice prior to appointment date.

THANK YOU FOR READING AND UNDERSTANDING OUR ADMINISTRATIVE AND FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS.

I HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION AND GIVE PERMISSION TO ALFREDO TREVINO JR., MD,PA TO FILE FOR SERVICES TO MEDICARE, MEDICAID AND/ OR ANY 3RD PARTY CARRIER ON MY BEHALF.

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Print Patient's NAME **Print "Responsible Party" NAME**

_____ **Date**:_____

Signature of Financial Responsible Party: