Columbia Eye Associates
Office Policies & Privacy Agreement

Welcome to Columbia Eye Associates, the office of Dr. Samuel Stopak and Dr. Rajiv Luthra. We strive to provide our patients with the best possible eye care. Our practice does accept medical insurance for the services we provide. We request your cooperation and understanding of our payment and office policies.

Office Financial Policy

Payment is due when services are rendered. Payment arrangements must be approved prior to check out. It is your responsibility to contact us promptly for assistance in management of your account. We are happy to process your insurance claims as a courtesy. Any such request must be accompanied with complete and accurate insurance information. We cannot guarantee payment of all claims by your insurance company. Reduction or rejection of your claim does not relieve you of your financial responsibility.

Your insurance coverage is a contract between you and your insurance company. Columbia Eye Associates is a specialty practice therefore your coverage differs between VISION and MEDICAL coverage. We suggest that you review your insurance plan prior to visiting our office so that you will be more familiar with your insurance plan guidelines.

Statements are mailed monthly and are due for payment within 30 days. Monthly statements will follow until the account is paid in full. If you have not paid your bill or have not set up a payment plan within 90 days, we will ask for the assistance of a collection agency.

Exams

If you are a managed care or HMO patient who requires a referral authorization, it is your responsibility to get this authorization from your primary care physician for your new or return visits. If we do not have an authorization on file at the time of your visit, you will be asked to pay for services rendered or reschedule your appointment. If your insurance covers the office visit or testing, we will submit your claim. If your insurance requires a co-payment from you, we will collect this at the conclusion of your visit. We accept cash, check, MasterCard, Visa, Discover, American Express and CareCredit. Non-Covered services, co-payments or deductibles will be your responsibility.

Our office only submits to medical insurances for medical eye exams. **We do not submit to vision insurance or for vision services** (refraction, contact lens fittings, LASIK). Patients who are experiencing a medical eye issue, have had previous eye surgery or have a systemic disease (such as, but not limited to: diabetes, Bell's palsy, hypertension, lupus, etc.) will require a medical exam. **Medical exams do not include an eyeglass (refraction) or contact lens prescription**.

> *Please Note: Each visit is documented in your medical record and a diagnosis is made by the provider. Diagnoses are made based on medical information, not based on coverage by insurance companies. To request a diagnosis change solely for the purpose of securing reimbursement from an insurance carrier is considered insurance fraud and will not be done by our office. If you wish to use a routine eye care benefit, it is your responsibility to convey this to the doctor before the conclusion of your appointment.*

A refraction is required if you would like a glasses or contact lens prescription. It is in addition to the medical exam. If a patient requests an eyeglass prescription, the refraction is required. **Medical insurances DO NOT cover this service**. The refraction fee of **$60** is collected at the end of your visit.

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2440 M Street NW, Suite 516, Washington, DC, 20037
(202)659-0066 (tel)(202)466-2933 (fax)

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Contact Lens Evaluation

A contact lens evaluation is needed to generate a contact lens prescription; it is in addition to the eye exam. The contact lens evaluation is required if you have never worn contact lenses or do not have a current prescription. Medical insurance DOES NOT cover contact lens evaluations. All contact lens evaluations must be paid for in full at the end of your visit.

Prescription request/ Medication Prior Authorization

Some medication refills require an office visit, particularly when you have not been seen by your physician for an extended period. This is to ensure that medications are used safely and effectively. We will notify patients if an appointment is needed to fulfill a refill request. Medication refills require authorization by your physician; however the physicians are here on a daily basis. As a result, please allow at least three business days for processing prescription refills and prior authorization request.

Appointments

Appointments vary in length, depending on the eye condition being evaluated. Please allow at least 60-90 minutes for the appointment. Patients are dilated at least once a year or more frequently if necessary. Following the dilation, light sensitivity and difficulty reading may be experienced for a few hours.

Forms and Reports

In order to comply with HIPAA regulations, we charge a per-page fee payable in advance, if you would like a copy of your records sent to you or another physician. This per-page fee policy is available upon request. As always, if a collaborating physician (primary care or specialist) requests portions of your record to assist in your care, there will be no charge. We require 5 business days to gather and prepare medical records. Work release forms or sick benefit forms are completed will no charge, please inform the receptionist if you need this service. If you need a Motor Vehicle form completed, a $10 fee will be assessed.

Notice of Privacy Practices

Federal law mandates that medical offices provide access to their Notice of Privacy Practices. This notice outlines patient rights and our methods for protecting patient health information. By signing below, the patient (or legal guardian) has acknowledged that they have been offered or received a copy of the Notice of Privacy Practices or received a copy at our office.

Consent For Treatment/Acknowledgement of Office Policies

- ☐ I, _____ authorize the doctors of Columbia Eye Associates and the employees to perform treatments and procedures that are necessary for my treatment.
- ☐ I am aware of Columbia Eye Associates Office Policy. I understand if vision services are rendered, I am responsible for the out-of-pocket charge.
- ☐ I have been offered or received a copy of the Notice Of Privacy Practice.
- ☐ I hereby authorized Columbia Eye Associates to discuss my medical/billing information with my insurance carrier and my physicians (if necessary).

Patient Signature:_____Date:_____