

**Columbia Eye Associates**  
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## **Office Policies & Privacy Agreement**

Welcome to Columbia Eye Associates, the office of Dr. Rajiv Luthra. We strive to provide our patients with the best possible eye care. Our practice accepts medical insurances for medical services provided.

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 contact between you and your insurance company and coverage differs between **VISION** and **MEDICAL** coverage. Columbia Eye Associates is a medical specialty practice. We suggest that you review your insurance plan prior to visiting our office to be familiar with your specific plan guidelines.

**Statements are mailed monthly and payments are due within 30 days. Monthly statements will follow until the account is paid in full. If you have not paid your bill, 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 requirements a co-payment from you, we will collect this at the conclusion of your visit. We accept checks, major credit cards, 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) 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.*

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### **Eye-glass and Contact Lens Evaluations**

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 insurance does not cover this service. **The refraction fee of \$75** is collected at the end of your visit.

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 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 prior authorization by your physician; however, the physicians are here on a daily basis. Therefore, please allow at least three business days for processing prescription refills and prior authorization requests.

### **Appointments and Cancellations**

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. In the event that you need to reschedule or cancel an appointment, we ask that you give at least 24 hour notice. **Cancellations within 24 hours or missed appointments are subject to a \$60 fee.**

### **Forms and Reports**

In order to comply with HIPAA regulations, **we charge a \$50 fee if you would like a copy of your medical records.** 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 five business days to gather and prepare medical records. Work release forms or sick benefit forms are completed with no charge; please inform the receptionist if you need this service. **If you need a Motor Vehicle form completed, there is a \$40 fee.**

### **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 been offered or received a copy of the Notice of Privacy Practices at our office.

### **Consent for Treatment and Acknowledgement of Office Policies**

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

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_