**ALAMO EYE INSTITUTE, P.A.**
**LYNNELL C. LOWRY, M.D.**

# WELCOME TO OUR PRACTICE

In order to serve you properly and keep cost down we feel it necessary to define our financial policies. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and it is not a substitute for payment. **It is your responsibility to pay any deductible amount, co-insurance, co-payment, refraction fee or any other balance not paid for by your insurance.** These charges must be paid for at the conclusion of each visit. Please notify us if office procedures need a pre-authorization. **We must have a copy of your insurance card on file in order to submit your claim.**

## REFERRALS

If you have an insurance which requires a referral it is **your** responsibility to obtain the referral from your primary care physician **before your appointment**. Otherwise, the visit will not be covered by insurance and you will be responsible for the payment. Please notify us if your insurance requires pre-authorization for office procedures.

## LAB AND X-RAY

If your insurance limits which laboratory or radiology facility you may use please inform the technician or nurse. We cannot be responsible for knowing which laboratory or radiology facility each insurance requires.

## REFRACTION POLICY

The Centers for Medicare and Medicaid Services (CMS) uses a system - the Resource Based Relative Value Scale (RBRVS) - to determine the fees for all Medicare providers. Most of the other insurance companies use this same system to set their payment schedules. During your visit a refraction may be performed to determine your need for glasses or to evaluate if any further visual improvement can be achieved. This is not only a necessary and essential portion of your eye exam, and in many cases is the sole reason for the appointment. Please be aware that this is a non-covered service by Medicare, as well as most insurance companies, and is the responsibility of the patient. Our office currently charges $55.00 for this procedure.
We appreciate your cooperation in collecting this fee at the time of service.

## MISSED APPOINTMENT

A **$25.00** fee will be assessed for missed appointments.

## CONTACT LENS POLICY

We do not file contact lens charges to insurance companies.

**I have read and fully understand my financial responsibility.**

Signature: _____ Date: _____