Mark A. Latina, M.D. & Vicki Kvedar, M.D.

Advanced Glaucoma Specialists

Authorization to Bill Insurances and Patient Agreement

Welcome to our practice,

This agreement allows us to bill your insurance company for the medically covered services that we provide and outlines additional fees that may be charged.

As a patient of Advanced Glaucoma Specialists, I understand it is my obligation and responsibility to know if my insurance plan requires a referral, and or, authorization for services rendered. I understand that not supplying a referral and or authorization is a direct conflict with the agreement I have with my insurance company and I will be held fully responsible for all payments not reimbursed by the insurance company.

I also understand that I am financially responsible for any charges not paid by my insurance company. This includes, but is not limited to, copayments, deductibles and any charges incurred if a valid referral is required and is not obtained. Also, I will be responsible for **all charges** if I fail to provide or staff with the correct insurance information and I am responsible for all charges due to late filing that is a direct result of failure to provide complete and accurate insurance information.

I understand that if I do not show for an appointment or fail to cancel an appointment within 24 hours, I will be charged a fee of $25.00

There is a $25.00 per month fee for unpaid balances after 30 days.

I understand that Refractions – which is the testing required in order for the physician to give a prescription for glasses is not a medical service and **is not covered by insurance.** Please note: Since we are a medical practice we do not perform or bill for routine eye exams.

The charge for a refraction is $70.00 which is discounted to $35.00 if paid at the time of service.

My signature below confirms my agreement to be a patient in the practice of Advanced Glaucoma Specialists and North Shore Ophthalmologists in accordance with the terms set forth above and authorizes the practice to bill my insurance company for all medically covered services.

The term of this agreement is for a period of one year and must be resigned at first visit of each calendar year.

Patient Signature_____ Date:_____