Austin Ocular Prosthetics Center, LLC
Craig Pataky, BCO, BADO

Welcome to our office. We appreciate the opportunity to work with you. The Following information is provided for you benefit so that we may better serve you. Please initial stating you agree and understand the following:

_____1. **Payments:** All applicable fees, deductibles, co-insurance, or co-pays are patient's responsibility. We accept cash, checks, money orders and credit cards. Returned checks will be charged the bank service fee and will be added to your balance, and checks will no longer be accepted for a period of 3 months. Should my insurance carrier pay me directly, I will endorse the check and remit directly to the Ocularist.

_____ 2. **Appointment Time:** We ask that our patients arrive on time for their scheduled appointment time. Patients arriving past their appointment time may be rescheduled or seen on a stand by basis.

_____ 3. **Cancellations:** If you need to cancel your appointment, be sure to call us at least 24 hours before your scheduled appointment. If you fail to notify us of 3 missed appointments, we will charge you for any future missed appointments.

_____ 4. **HMO & PPO Referrals:** If your policy requires a written authorization from your Primary Care Physician. It will be your responsibility to make sure your visit is Pre-approved, and you must have a referral at the time of your visit, or you will be responsible for payment in full. Our service are considered *out-of-network*. This means that a pre-certification or prior-authorization may be required for your insurance to cover these services as in-network. This can be initialized and obtained by calling your insurance co. or physician, depending on your particular policy. It is your responsibility to know wither your policy/plan requires pre-certification or prior-authorization.

_____ **5. Changes of Information**: Please provide us with any changes regarding your address, phone number, physician or any insurance information as soon as possible.

_____ **6. After Hours Care:** If it is an emergency please call your ophthalmologist. If it is a non-emergency you can leave a message and we will return your call on the next business day.

_____ **7. HIPPA:** I have received notice of Austin Ocular Prosthetics Center, LLC. Privacy Polices. Read, acknowledged and understand all statements. The office may share information about me with others though FAX communication devices. There is a small risk that confidential information may be accidentally transmitted to people not authorized to receive it. I will notify the office if I do not wish my information to be transmitted by FAX. I understand that FAX communications expedite my care. The office may leave messages on telephone answering massages. These messages may contain confidential information. I will notify the office if I do not wish them to leave messages. I will notify the office of any Privacy restriction or limitations.

_____ **8. Non-Compliance:** We reserve the right to discontinue care with our office for non-compliance or any of the above policies.

_____ **9. Signature on File:** I irrevocably assign payment directly to the undersigned Ocularist of the medical benefits, if any, otherwise payable to me for her services as described. I am responsible and will pay any outstanding bill for services not covered by my insurance. I authorize the Ocularist to release any information acquired in the course of my examination or treatment to my insurance company, and acknowledge that a photo static copy of this authorization is as valid as the original.

"I, the guarantor of payment and responsible party, agree to the above policies and agree to the terms regarding payment and payment responsibilities."

_____ _____

Signature **Date**

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Print Name