



LaFace by
Laura Phan MD

PATIENT AGREEMENT TO SERVICES AND FINANCIAL RESPONSIBILITIES

I, the undersigned, hereby authorize LaFace by Laura Phan, MD, Inc to perform appropriate assessment, diagnostic, and treatment procedures. I also authorize LaFace by Laura Phan, MD, Inc to obtain historical and eligibility data from various public and private entities, including but not limited to insurance claims data, pharmacy data or prior treating providers. The information may be necessary to determine eligibility for services and to properly diagnose and treat my conditions. Additional consents may be required to release this information.

I, the undersigned, have insurance coverage and assign directly to LaFace by Laura Phan, MD, Inc all surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am personally responsible for verifying network eligibility and benefit before and during assignment to LaFace by Laura Phan, MD and am responsible for all **co-payments, co-insurances, deductibles and non-covered services**, as dictated by my insurance coverage. I understand that it is the policy of this practice that all **estimated co-payments, co-insurances, deductibles and non-covered services** are collected at the time of service. The amount is based on the contractual agreement with my insurance plan. I understand that I am personally responsible for payment of fees if authorization has not been obtained for whatever reason. I understand that being in net-work or having authorization **does not guarantee payment** by insurance plan. I understand that I am personally responsible for all charges whether or not paid by insurance by 90 days of service. I authorize LaFace by Laura Phan, MD, Inc to release to my insurance carrier(s) any medical information necessary to secure payment of benefits. I permit a copy of this authorization to be used in place of the original. If I do not have health insurance, I am responsible for full payment for all services rendered by the Practice and agree to pay the entire amount at the time of service. I understand that if I do not pay in full I may be discharged from the Practice.

I understand that, in addition, to the examination, there may be diagnostic tests (i.e., visual field test, tear duct system probe and irrigation, CT and MRI scan, lab, etc.) and photographs taken as part of my evaluation. These are performed to help in the diagnosis and management of the medical conditions. I understand that, as a result, there may be additional out-of-pocket costs, as dictated by my insurance coverage.

I understand that it is the standard of care for Dr. Phan and the Practice to take patient photographs prior to and following the initiation of most clinical treatments and/or the performance of any surgical procedure on patients of the Practice. The photographs may be used for patient education or promotion and will not contain name or any other identifying information. I will inform the office if I do not wish to have my photos used for these purposes.

I do not wish to have my photos and videos used for patient counseling or medical education.

I do not wish to have my photos and videos used for promotion, including social media.

I understand that if I have not been examined by an eye doctor in the past year, as part of my examination with the Dr. Phan, I may be dilated, which involves having drops placed in my eyes. Dilation may cause blurred vision for several hours and make bright lights more bothersome, which vary from person to person. In extremely rare cases, dilation may trigger acute angle-closure glaucoma. I understand that I am to inform the doctor if I do not wish to have my eyes dilated at the time of examination.

I understand that if I “no-show” an appointment I will be charged \$100. I understand that if I no-show two appointments I will need to place a valid credit card on file when making future appointments and pay the full amount of the appointment if I no-show the third time. I understand that should I no show or cancel a total of three appointments, I may be discharged from the Practice.

All Medicare patients must sign lifetime beneficiary claim authorization: I request that payment of authorized Medicare benefits be made either to me, or on my behalf, to LaFace by Laura Phan MD, Inc., for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made, and authorizes release of information necessary to pay the claim. If other health insurance is indicated in Item 9 of the electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for deductibles, copays, and non-covered services. Co-insurance and the deductible are based on the charge determination of Medicare carrier.

As a courtesy to our patients we will submit medical claims and continue to work with insurance plans to get the claims processed in a timely fashion. After 90 days from the date of service, we will no longer be contacting the insurance plans on the patient's behalf regarding claim status, and the patient is now responsible for full payment of services rendered. I understand that I am responsible for all charges not paid by insurance after 90 days from the date of service and that I am responsible for keeping my coordination of benefit up to date and working with my insurance plan to ensure for payment.

Recurring Payment Authorization

Our credit card processor may store credit card numbers used for recurring payments as a convenient method of payment for services or products that medical insurance plan does not pay (i.e., deductible, co-insurance, co-pay, or non-medically necessary or cosmetic procedure or product.) Your card information is stored confidentially and securely by encryption. Charges to your card are typically processed only after the claim has been filed and processed by the insurance plan. There are times where we may charge your card before processing the claim but this would be discussed with you beforehand. We will notify you via OnPatient or email, or postage mail if you do not have access to a computer or email, prior to charging your credit card. We will also send you a receipt of payment via OnPatient, email, or postage mail.

Recurring payments is convenient and efficient. It saves time, paper and postage. Your payments are always on time.

I, the undersigned, authorize and request LaFace by Laura Phan, M.D., Inc. to charge my credit or debit card on file for balances due for services or products rendered the Practice.

I certify that I am an authorized user of this credit or debit card and will not dispute these transactions with my bank or credit card company, so long as the transactions correspond to the terms indicated in this authorization form.

This authorization will remain in effect until I cancel this authorization. To cancel, I must give a 15-day notification to LaFace by Laura Phan, M.D., Inc., and the account must be in good standing.

Patient's (or Legal Guardian's) Signature

Date

Print Name