Paul M. Scott, M.D., P.A. 7500 Beechnut, Ste. 256, Houston, TX 77074 713.988.0121

OPHTHALMOLOGY

Insurance Billing Policy

Most of out patients are now managed care Insurance programs in which we participate. Part of our agreement with these Insurance companies is that they pay the claims in a timely manner. This means in 90 days or less. With proper proof of your Insurance coverage, we will be happy to file your medical claims. However, if payment is not received from your Insurance company in 90 days, we do ask that you accept responsibility for the charges. Should the claim be paid at a later date, the money will be promptly refunded to you.

We do have staff diligently at work to assure that claims are paid on a timely basis. However, delayed or unpaid claims may be due to circumstances beyond our control. Therefore, if your claim has not been paid within 30–45 days (you should receive an explanation of benefits when a claim is paid) it would be helpful if you could call the Insurance company and check on the status of the claim. In many cases, the Insurance company had pended the claim while awaiting Information from the patient.

Although we verify benefits at the time of the visit, the claim may processed at a different benefit level. This is an issue that must be discussed between you and your Insurance company, as information regarding a change in benefits can only be discussed with the insured. If you have been told your claim will be reprocessed, please provide our office with the **name and phone number** of the person with whom you spoke for follow-up, if needed.

These polices allow for quicker and more “hassle-free” claims processing. By following these policies, you could avoid paying the entire balance from your visit.

By signing below, I acknowledge that I have been informed that all charges left unpaid after 90 days by my insurance company, after contractual adjustments, will be my responsibility. This form may be revoked only upon written signed notification.

______________________________ ____________________

Patients signature Date

OPHTHALMOLOGY

Patient Consent For Use & Disclosure of Protected Health Information

I herby give my consent to use and disclose protected health information about me to carry out treatment, payment and healthcare operations. (Paul M. Scott, M.D., P.A. Notice of Privacy Practices provides a more complete description of such uses and disclosures, is posted in the office and has been read by me.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Paul M. Scott, M.D., P.A. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice Of Privacy Practices may be obtained by forwarding a written request to Paul M. Scott, M.D., P.A. at 7500 Beechnut, Suite 256, Houston, Texas 77074.

With this consent Paul M. Scott, M.D., P.A. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Paul M. Scott, M.D., P.A. may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards and patient statements. I have the right to request that Paul M. Scott, M.D., P.A. restrict how it uses or discloses my protected health information to carry out treatment, payment and healthcare operations.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Paul M. Scott, M.D., P.A. use and disclosure of my protected health information to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Paul M. Scott, M.D., P.A. may decline to provide treatment to me.

______________________________ ____________________

Patient’s Signature or Legal Guardian Date

____

Patient’s Name (Printed)

Paul M. Scott, M.D., P.A. 7500 Beechnut, Ste. 256, Houston, TX 77074 713.988.0121

Dear Patients,

* We require healthcare coverage ID Cards at or before EACH and EVERY visit. Please present your card to the receptionist. If you have insurance we will gladly process your claim, but we request that you pay your bill at the time of service, unless financial arrangements have been made prior to your office visit. Please advise if there has been any change in your address, phone number or insurance coverage.

* There is a $35.00 fee for all returned checks.

* There will be a $50.00 fee if you do not show up for your appointment, or if you cancel on the day of your scheduled visit. This fee is your responsibility and will not be processed to your insurance company as it is considered a “non-covered” item.

The nature of our practice is to give our patients the utmost in care and service. Sometimes there are unanticipated delays. Please excuse any delays. Well will give YOU the same careful attention as soon as possible.

Our practice continues to grow by your referrals. Thanks so much for your trust and confidence!

____________________________ ______________

Signature Date

Paul M. Scott, M.D., P.A.   7500 Beechnut, Ste. 256, Houston, TX 77074   713.988.0121

OPHTHALMOLOGY

Refraction Policy

Refraction is the process of determining the eye's refractive error, or the need for corrective spectacles and/or contact lenses. It is an essential part of an eye examination, but it is NOT a covered service by Medicare and/or most insurance companies.

Our office fee for a refraction is $80.00 and this fee is collected in addition to the patient's co-pay and deductible. Your cooperation in paying this fee is very much appreciated.

ACKNOWLEDGEMENT:

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. The co-pay is a separate form, and not included in the refraction fee.

______________________________ ____________________

Patient's Signature or Legal Guardian   Date

Paul M. Scott, M.D., F.A.C.S., P.A.

Payment is Requested at the time of the exam by Cash, Check or Credit

Last Name	First Name	Middle Name	
Address	City	State	Zip
Birthday	Soc. Sec. #	Age	Sex
Marital Status S M W D	Phone #	Cell Phone #	
Employer	Occupation	Supervisor	
Employer Address	City	State	Zip
Work Phone #	Email		
Spouse or Guardian	Birthdate	Phone #	
Primary Insured	Relation To Insureed	Insurance Co.	
Ins. Address	Phone #	Policy #	Group #
Secondary Insured	Relation To Insured	Insurance Co.	
Ins. Address	Phone #	Policy #	Group #
Family M.D.	Phone #	Fax #	
Who Referred to this Office			
Medicines now Taking			
Allergy to Medicine			
Operations or Surgery			
In Case of Emergency (Friend or Relative not living at same address)			
Name	Phone #	Relationship	
Person Responsible for account if other than Patient.			
Name	Phone #	Relationship	

The patient is ultimately responsible for all bills, and full payment is expected unless other arrangements have been made and approved by the office manager in advance. Your signature below acknowleges acceptance of this office policy.

Signature *Date*