



Dr. Katie Kaufman, O.D.

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FINANCIAL POLICY

- Refraction is a test used to determine eye glasses prescription. Some insurance companies do not cover the cost of refraction, currently set at \$60, and patients will be billed this amount upon denial from their insurance carrier. Medicare does not ever pay for refractions; patients with Medicare will be required to pay this fee at the time of service.
- Payment is expected at the time services are rendered unless arrangements have been made prior to treatment.
- As a courtesy to our patients, our office will file insurance claims for Dr. Katie Kaufman with participating insurance carriers and vision plans. However, Dr. Kaufman does not participate with all plans. Each patient is responsible for verification of their coverage. We will be happy to assist you on a limited basis with your authorization process, but we encourage you to familiarize yourself with the specifics of your plan prior to your visit, particularly pertaining to co-pays, deductibles, routine eye coverage, etc.
- If your verification and authorization is not pre-approved before your visit you will be responsible for full payment of professional fees and materials on the day of your visit. We are unable to make any exceptions to this policy.
- If we do not file insurance for your services, we will provide a receipt so that you are able to file for personal reimbursement, if any.
- HMO insurance policies require a referral from the primary care physician, which the patient is responsible for obtaining that referral prior to the visit.
- Any outstanding balances more than 120 days will be forwarded to our collection agency unless payment arrangements have been made with our Account manager. You will be responsible for all fees charged by the collection agency.

Please read, initial and sign below:

(Initial) _____ FINANCIAL RESPONSIBILITY: I understand that I am responsible for any charges not covered by my insurance, including co-pay, co-insurance and deductible payments. Payment is due at the time of service. I understand that I am responsible for any authorization or referral my insurance may require, prior to the time of service. I understand that I am ultimately responsible for payment on my account.

(Initial) _____ INSURANCE COVERAGE: I understand that it is my responsibility to update Westlake Eyecare with current, accurate insurance information at each visit. I will be responsible for any balance due as a result of not disclosing this information.

(Initial) _____ FEE FOR MISSED APPOINTMENTS: I understand that there is a \$40.00 fee for missing a scheduled appointment. Westlake Eyecare requires a 24-hour notice for appointment cancellations, a charge that is not covered by insurance.

Patient/Guarantor Signature

Date

Questions or concerns should be directed to our billing department.