S I G H T L I N E

Laser Eye Center & Ophthalmic Associates

2100 CORPORATE DRIVE, SUITE 400 WEXFORD, PA 15090 P (724) 933-5588 F (724) 933-6051

Welcome to our office!

Your doctor has referred you to our office for testing. We are honored that your doctor has selected us to participate in your care.

Testing is often ordered to help diagnose a condition. If the testing does not reveal a covered diagnosis, your insurance company may determine that it is not medically necessary. Health insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. When you receive an item or service that is not a covered benefit, you are responsible to pay for it at the time of service. The cost for testing services usually ranges from $50 to $100 per test.

Please complete both pages of the **HEALTH HISTORY FORM** (linked below). This will shorten your time in the office. If you have any trouble completing this information, someone from our office will be happy to help you at the time of your visit. Please bring your form and your **MEDICAL INSURANCE CARD(S)** with you to your appointment.

Do not hesitate to call our office if you have any questions. We look forward to meeting you!

Sincerely,

The SightLine Doctors & Staff

SightLine Laser and Ophthalmic Associates
ADVANCE NOTICE & ACKNOWLEDGEMENT OF POLICIES

HIPAA PRIVACY POLICY

A copy of our Notice of Privacy Practices is posted at the front desk and can be found in our 'Privacy Binder'. You have the right to have a copy of this policy. Please see a staff member to request a copy of our HIPAA policy for your records. Signing below acknowledges that you have had the opportunity to review the Notice of Privacy Practices and have been offered a copy.

REFRACTIONS

A refraction may be performed at your evaluation and/or subsequent follow-up visits. This is a test to determine the best possible vision. This test is a separate component to the medical exam and is NOT COVERED BY INSURANCE PLANS. Our current fee for this service is $45.00. If you choose to pay for the refraction on the day of service, a $10 cash discount will be extended.

ASSIGNMENT OF BENEFITS

Signing below authorizes and directs your insurance carrier(s), including Medicare and private insurance plans, to issue payment check(s) directly to SightLine Ophthalmic Associates for medical services rendered to you and/or your dependents. You also authorize the release of any information needed to determine benefits and submit claims for these services.

FINANCIAL RESPONSIBILITY

Fees (including co-pays) are due and payable on the date that services are rendered. You have requested medical services from SightLine Ophthalmic Associates, and by making this request, you become fully financially responsible for any and all charges (including co-insurance, deductibles and non-covered services) incurred in the course of the treatment authorized.

By signing below, I am confirming that I have read and understand this notice and confirm that I have been given the opportunity to ask whatever questions that I might have and that they have been answered to my satisfaction.

_____
Patient Name (print)

_____ _____
Signature Date