BOSTON EYE CARE CONSULTANTS

Robert A. Lytle, MD
Eye Physician and Surgeon

Hyannis Office
51 Main Street, Hyannis, MA 02601
(508) 771-6447 FAX: (508) 775-5104

Falmouth Office
14 Bramblebush Park, Falmouth, MA 02540
(508) 540-0511 FAX: (508) 775-5104

FINANCIAL POLICY

ALL CO-PAYS ARE REQUIRED AT TIME OF SERVICE

Please intial by your insurance type:

___ HMO PLANS: You are responsible for getting proper insurance referrals/authorizations in advance of your appointment. You will be responsible for payment of services denied by your HMO for lack of pre-authorization. *We reserve the right to reschedule your visit if the referral is not in place at the time of your visit.*

____ PPO PLANS: We have agreed to accept the discounted rate for your insurance plan, however all co-insurance is your responsibililty.

____ POS PLANS: We have agreed to accept the discounted rate for your insurance plan, however all co-insurance is your responsibililty.

____ MEDICARE: As a participating provider, we will bill Medicare. You are responsible for your annual deductible and 20% co-insurance. We will also bill your secondary insurance. If a balance remains after Medicare and secondary insurance we will bill you for any balance.

____ SECONDARY INSURERS: We will bill your secondary insurers. You are responsible for any balances after your primary and secondary insurance payments. *We do not bill tertiary insurance.*

____ STATE INSURANCE: We take most state health insurance plans. You are responsible for any insurance referrals/authorizations. *We reserve the right to reschedule your visit if the referral is not in place at the time of your visit.*

____ SELF PAY: You are required to pay for your visit IN FULL at time of visit.

____MINOR PATIENTS: The adult accompanying a minor and the parents/guardians of the minor are responsible for providing insurance information or payment in full at time of visit.

___ SERVICES NOT COVERED BY YOUR INSURANCE: We will try to provide prior notification if you are going to receive a service not covered. One of these services is a refraction (a new glassees prescription). There may be other services as well.

____ YOUR INFORMATION: *It is your responsibility to keep us informed of any changes in your insurance coverage.*

____ RECORDS: There is a $25 fee for printing out your chart. There is NO fee to transfer records electronically to another medical facility. We require a signed Records Release form prior to sending your records. We do not send records through email.

____ RETURN CHECK FEE: There is a $75 fee for all returned checks. Future payments must be made with cash, money order, or credit card.

____ NO-SHOW FEE: There is a NO-SHOW fee of $50 if you do not come to your appointment.

You understand and agree that you are responsible for all char ges pertaining to your medical care, regardless of your insurance status. It is also your responsibility to inform the office of any changes in your contact information, such as mailing address and phone number. You will notify the office of any changes that should be made in your chart.

SIGNATURE: _________________________________ DATE: ____________