

Primary Eye Care Associates OD, PA

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Revised 6/11

OFFICE POLICIES OF M. STEVEN SATTERFIELD, OD

CONFIDENTIALITY AND RECORDS POLICY

All information shared in your treatment is confidential, except circumstances governed by law. If you would like copies of any of your protected health information, you will need to sign a release of records form. We reserve the right to charge a minimum fee of \$15.00 for the copying of medical records; the cost may be higher for color copies and extensive records.

CONTACT LENS SERVICES

Contact Lens Evaluation/Fitting for new and established contact lens wearers: An exam for contact lenses includes special tests that are not typically performed during a routine eye exam for eyeglasses such as curvature of the eye, diameter, checking tear film and lifestyle of the patient. Contact lenses rest on the eye whereas eyeglasses do not; therefore, there is an added fee to the routine exam. Patients who would like to be fitted or re-fitted for contact lenses will incur a fitting fee. This fee is calculated by the type of lens and material suited for the patient. Fittings or refitting will include a free pair of trial lenses. RGP fittings do not include trial lenses.

FINANCIAL POLICY

The patient is responsible for knowing their own insurance benefits, eligibility and coverage. If you have insurance which provides coverage for the services performed by Dr. Satterfield, we will gladly file your insurance for you as a courtesy. However, if we are not a provider listed with your insurance you will be responsible for payment in full at the time of service and we will give you the paperwork required to file you own insurance. We are not obligated to file all secondary insurance, except for Medicaid. **In the event a patient has routine/well vision benefits and medical conditions are discussed or discovered, the visit will be filed with your medical insurance and the appropriate co-payment will be applicable.**

All insurance for which we are a listed provider will be filed and then refiled one time only. Due to the changing nature of insurance companies and coverage we cannot repeatedly refile your insurance on your behalf. Any balance remaining after 90 days will be transferred over to the patient's responsibility-- it will become the patient's responsibility to contact their insurance company to obtain reimbursement for payment made to our office. Medical records are the doctor's property and copies of medical records will typically be released only after all balances are paid.

NO SHOW, CANCELLATION POLICY AND EMERGENCY INFORMATION

Your appointment has been reserved for you. Many patients with medical needs are unfortunately forced to wait several days before they can be worked in to our schedule; therefore, we require a 24 hour notice for cancellation of your appointment. If you fail to give us at least 24 hours notice you will be charged a \$25.00 cancellation fee, and may be at risk of being released from the practice. We have an answering machine for after hours, emergencies and information regarding your appointment. If you have questions regarding you glasses or contact lenses, or questions about a bill, please call during our regular office hours of 8:30 to 5:00 Monday through Thursday 8:30 to 3:00 on Friday. Our office is closed for lunch each day from 12:00 to 1:00.

I HAVE READ, UNDERSTAND AND AGREE TO THIS POLICY. THIS DOCUMENT SUPERSEDES ANY OTHER AGREEMENT WHETHER IT IS WRITTEN OR VERBAL.

Signature: _____ Date: _____

Parent or Guardian: _____
(If patient is a minor)