

## Warren Ophthalmology Associates, Co.

Welcome to Warren Ophthalmology Associates, the office of Dr. Zafar Sheik, Dr. Frank D 'Apolito, and Dr. Carla Darak-Bolino. We are committed to providing you with the best possible eye care. If you have insurance coverage for the services provided, we want to assist you in receiving your maximum allowable benefit. In order to achieve these goals, we need your cooperation and understand of our payment policies.

### Office Financial Policy

Payment is due when services are rendered, unless payment arrangements have been approved. We are also happy to process your insurance claims as a courtesy. Any such request must be accompanied with complete and accurate insurance information.

We must emphasize that your insurance coverage is a contract between you and your insurance company. We are a specialty practice. Your coverage may differ between **VISION** and **MEDICAL** coverage. The filing of insurance claims is a courtesy extended to our patients. All charges are your responsibility the date service is provided. We realize temporary financial difficulty may affect the timely payment of your account. It is your responsibility to contact us promptly for assistance in the management of your account. Remember we are here to help you.

OFFICE VISITS: If you are a managed care or HMO patient who requires a referral authorization, it is your responsibility to get this authorization from your primary care physician for your new or return visits. If we do not have an authorization on file at the time of your visit, you will be asked to pay for services rendered, or your visit may be rescheduled.

If your insurance covers the office visit or testing, we will submit your claim. If your insurance requires a co-payment from you, we will collect this at the time of your visit. We accept cash, check, MasterCard, Visa and Discover. Non-covered services, co-payments, or deductibles will be your responsibility.

Warren Ophthalmology Associates accepts assignment from Medicare. We will submit your claim to Medicare and to your secondary or supplemental insurance. You are responsible for the coinsurance amount, which is 20% of the Medicare Approved charge and any unmet deductible or non-covered charge. ***Vision exams are not covered by Medicare. Medicare will NOT pay for any vision testing.*** Health exams ***are*** a covered service. If you have any questions as to what your insurance covers please feel free to call the office and we will do the best we can to assist you.

BILLING AND CREDIT: Statements will be mailed monthly and are due for payment within 30 days. Monthly statements will follow until the account is paid in full. If you have any questions, please feel free to discuss them with our Insurance/ Billing Clerk by calling 330-856-3304. If you have not paid your bill, or have not set up a payment plan within 90 days, we will ask for the assistance of a collection agency.

FORMS AND REPORTS: Our office will complete without charge, sickness benefit forms, and work release forms related to treatment or surgical services. A charge will be assessed for requests for copies of records. We require five business days to gather and prepare medical records to leave the office.

Warren Ophthalmology Associates, Co.  
3921 East Market Street  
Warren, OH 44484  
330-856-3300

Zafar A. Sheik, M.D.

Frank A. D'Apolito, O.D.

Carla Darak-Bolino, O.D.

**CONSENT FOR TREATMENT**

The undersigned Patient/Guardian has received a copy of our financial policy and hereby authorizes the Doctors of Warren Ophthalmology Associates, Co. and the employees, to perform any treatment of procedure they may deem necessary for the Patient's treatment.

\_\_\_\_\_/\_\_\_\_\_  
Signature of Patient/Guardian Date

I hereby authorize the staff of Warren Ophthalmology Associates, Co. to release information to insurance carriers, appropriate physicians and/or Workers' Compensation departments, as required. Concerning my illnesses and treatments and authorize all payments to be made to Warren Ophthalmology Associates. I understand that if I did not get prior authorization as required by my insurance, that I will assume all financial responsibility for such charges associated with my visits.

- I am aware of Warren Ophthalmology Associates Office Financial Policy
- I have been offered or have received a copy of Warren Ophthalmology Associates "Notice of Privacy Practices"
- I hereby authorize Warren Ophthalmology Associates, Co. to discuss my medical/billing information from this date forward to any or all of the persons listed below:

\_\_\_\_\_/\_\_\_\_\_  
Name Relationship

\_\_\_\_\_/\_\_\_\_\_  
Name Relationship

\_\_\_\_\_/\_\_\_\_\_  
Signature of patient or representative Date

**May we leave a message on the answering machine?**     **Yes**     **No**