Pediatric Eye Care

1636 Aviation Blvd, #202
Redondo Beach, CA 90278
Office (310) 374-2727
Fax (310) 374-2722
www.pedseyela.com

Welcome to Pediatric Eye Care, the office of Dr. de Castro,

We are very appreciative of you entrusting us in your or your child's eye care. We have a few things we need to go over prior to initiating care. Below is the clinic's Mission, Vision and Values Statement which drives us in the care for our patients in this clinic.

Our Mission

To provide comprehensive eye care for children and young adults and to correct strabismus in patients of all ages.

Our Vision

Evidence-based care and treatment for a lifetime of better vision and eye alignment.

Our Values

Evidence-based care: to offer treatments options that are aligned with the best evidence available.

Family-Oriented: Empowerment of patients and parents through top quality experience and education. To provide adequate knowledge and understanding to make the best decision for each patient and family.

Best Vision: Goals for each patient include the best possible vision in each eye, eyes that are straight and eyes that are working together.

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Office Policies

Patient Name:_____ Date of Birth: _____

PLEASE NOTE: THIS IS A SUMMARY OF THE OFFICE POLICIES OF PEDIATRIC EYE CARE, BY SIGNING BELOW YOU HEREBY AGREE TO THE TERMS OF THIS CONTRACT. IF YOU DO NOT WISH TO ACCEPT THESE POLICIES, PLEASE NOTIFY OUR STAFF SO APPROPRIATE MEDICAL CARE MAY BE PROVIDED FOR THE PATIENT.

1. **Time**: We believe all patients deserve our special attention. Our ability to stay on schedule is affected by many factors included giving each patient and family the time they need for their assessment and discussion of options for treatment. Sometimes, patients are added on as an emergency basis and may need acute care. Understand that we are doing our best to stay on schedule but please plan on being in the office between 1-2 hours for new patients and dilated visits and about 1 hour for return visits. Please make sure you have toys/snacks/activities/bottles for your child.
2. **No Shows/Late Cancellation:** Federal law (Medicare) and CMS require all patients be treated the same in an office. **We have a $50 no show policy**. You **are not** required to be seen in this office by your health plan. By accepting a visit in our office, **you agree** to our policy, regardless of your health plans state, federal, or insurance policy guidelines. Thus, if you miss an appointment that you scheduled and do not notify us within 24hrs of the visit you will be billed $50 for the missed appointment and rescheduling. If you feel you have a valid reason for missing the appointment and did not notify us, you must present to the office a written reason for your missed appointment to have the exam rescheduled and the fee may be waived at the discretion of our clinic. While we try to contact (text/call) everyone to remind them prior to their appointment, if we cannot or do not reach you, you are still responsible for the missed fee if you "no show". Thus, it is imperative that you keep all contact information current with our office.
3. **Contact Information:** It is your responsibility to have current contact information on file. You must have a valid ID on file and a copy of current insurance cards with you to be seen. Likewise, a working phone number and current address must be provided at each visit as well as at least one emergency contact not living with you.
4. **Non-Covered Services**: There are services that are provided as part of your or your child's eye care that may not be covered by your insurance (such as a refraction). These services will be provided after a discussion of them with you. Please see the Advanced Beneficiary Notice for some examples and specifics. If you have any questions, please do not hesitate to discuss with your doctor or our staff.

I understand, agree to, and accept the following terms and conditions above:

_____ _____

Signature of Patient or Guardian **Date**

☐ **I do not agree to the above terms and conditions**

For Office Use Only

____ Patient seen on a one time emergency basis, family informed of need to find non-emergent care elsewhere
____ Patients condition deemed non urgent/ emergent and sent/ referred to another provider.

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FINANCIAL RESPONSIBILTY AND AUTHORIZATION FOR CARE

Patient Name: _____ D.O.B: _____

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. To achieve the goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our clinic. We accept cash, checks, MasterCard, Visa or American Express, and most other major credit cards.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

Please understand the following:

1. Your insurance is a contract between you, your employer, and the insurance company.
2. Our fees are generally considered to fall within the acceptable range by most insurance companies, and therefore are covered up to the maximum allowance determined by each carrier. If this is not the case, the patient is still liable for the remaining balance.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. For example, most insurance policies will not cover routine eye exams and refractions, thereby making the patient completely responsible for the charge.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. All charges are your responsibility from the date the services are rendered unless the contract between our office and the insurance company states otherwise. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help.

I ASSUME ALL FINANCIAL RESPONSIBILTY FOR THE ABOVE PATIENTS' CARE AND AUTHORIZE TREATMENT.

Initials_____

Authorization to Release Medical Information to My Health Plan

Patient Name: _____ D.O.B: _____

I request that payment of authorized insurance benefits be made on my behalf to **Alex de Castro-Abeger, MD.** I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that my signature requests that payment be made and authorizes the release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of the information to the insurer or agency shown.

I realize I am responsible for the deductible, co-deductible, co-insurance and non-covered services.

Name of Person Signing Form: _____

Signature: _____Date_____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____ Telephone: _____
Address: _____
Patient Number: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENT CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: Telephone: (310) 374-2727, Fax (310) 374-2722.
Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

SIGNATURE:

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name: _____
Relationship to Patient: _____

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YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

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Advanced Beneficiary Notice of Non-Covered Services

Patient Information:

- Full Name: _____

- Date of Birth: _____

- Guardian Name: _____

I,_____ , understand and acknowledge the following information regarding certain services that may not be covered by my medical insurance plan:

1. **Refraction:** I am aware that refraction, which determines my eyeglass or contact lens prescription, might not be covered as part of my regular eye exam under my insurance plan. Refractions will range from **$50-100** depending on the type and complexity of the refraction.

2. **Contact Lens Fittings/Exams:** I understand that contact lens fittings involve specialized tests and evaluations. Medical insurance does not regularly cover these services and they will have associated costs ranging from **$75-$300** that I will be responsible for covering if it is an uncovered service.

3. **Other Non-Covered Vision Services:** I understand that there may be additional services related to my eye care that are not covered by my insurance plan. These services could include specialized tests, advanced diagnostic procedures, or elective treatments. These may include fundus photography, optical coherence tomography, topography, axial length measurements, visual fields. If they are not covered by insurance or done for a non-covered reason, determined by your insurance, then I will be responsible for their costs. These costs can range from **$40-150**

4. **Optical Goods:** I acknowledge that there could be limitations on insurance coverage for eyeglasses, contact lenses, and other visual aids.

I have had the opportunity to ask questions about my insurance coverage, the potential costs of specific services, and alternative options available. I am aware that the clinic's staff is available to assist me in making informed decisions about my eye care.

By signing my full name below, I acknowledge that I have read and understood the information provided in this form regarding uncovered vision services.

Signature: _____ Date: _____

(Patient and/or Guardian to sign)

Please check one:

[ ] I would like to receive a copy of this form for my records.

[ ] I do not need a copy of this form.

Clinic Use Only

Staff Member (Initials): _____ Date: _____