DOUGLAS J. LAVENBURG, M.D., P.A.

DelMar Surgical Center, LLC
103 Chesapeake Blvd., Suite C Elkton, MD 21921
One Centurian Drive Newark, DE 19713
410.392.6133|302.993.0722

Financial Agreement

Thank you for choosing Douglas J. Lavenburg, M.D., P.A. and the Delmar Surgical Center, LLC for your family eye and skin care needs. We are pleased to welcome you to our practice. Our chief concern is that you and your family receive the finest care for maintaining healthy vision.

We understand that occasionally some of our patients will experience financial difficulties. It is our hope that you will bring these situations to the attention of our billing department or office manager to allow us to help you manage your account in the most effective manner. Please be advised that your insurance company is a contract with you and your employer, not our practice. We will be glad to submit your claims for payment, however, the final responsibility for payment due for services rendered is the sole liability of you, the patient or the guarantor.

Our financial policy is as follows. Please feel free to discuss this with our billing department at any time. Please complete all insurance information, read our financial policy, and sign below to verify the receipt of this information.

1. We accept cash, check, Visa, MasterCard, Discover or Care Credit. We do not accept American Express.
2. Medicare and some other insurance carriers do not pay for your refraction (checking your vision). A fee of $35.00 is due at the time of your visit.
3. If Medicare is your primary insurance, and your visit is for a medical condition, we will gladly submit your insurance claim to Medicare for you. You will be responsible for any co-insurance and/or deductible.
4. Your co-payment and self payment amounts are due at the time of service.
5. You are financially responsible for all payments not paid by your insurance company.
6. If we do not participate with your insurance carrier, payment is due at the time of service.
7. If your insurance carrier requires a referral from your primary care provider for treatment, it is your responsibility to obtain the referral prior to your appointment. If you do not obtain and provide the referral within the time allowed by your insurance carrier, you will be financially responsible for services rendered.
8. **Returned checks are subject to a $25.00 service charge.**
9. **Any cancellation of product will incur a 20% fee.**
10. It is your responsibility to advise our office if you are being seen as part of a Vision Benefit Package provided by your employer prior to your appointment.
11. We are happy to provide any counseling on our billing practices, however, if your account is not paid within 60 days you will be responsible for payment plus a monthly finance charge of 1.5% per month.
12. If we are participating with your insurance company, we are contracted to adjust your account by a certain amount which is known as a "contractual write-off". This does not mean you will not have a balance. We will bill you for monies as directed by your insurance company.
13. If your account goes into "collections", in addition to your outstanding balance, you will be responsible to pay a 25% fee charged by the collection agency as well as any legal or court costs as specified by our collection agency.
14. Any Medical Necessity forms/letters required by your insurance company, or any communication outside the usual and customary forms required for billiing or communication with other physician providers, will be subject to a $25.00 administrative fee(including MVA forms).
15. We will be happy to complete your disability forms which are subject to a $25.00 administrative fee.
16. As a courtesy to our patients relocating out of the area, we will be happy to supply your new eye care provider a copy of your medical records at no charge. Any other requests for copies of medical records will be subject to a $25.00 administrative fee.
17. You will have 90 days from date of exam to return for a recheck of your glasses prescription for a fee of $35.00. There will be a courtesy waiver of this fee for glasses purchased at our optical locations. After 90 days, a $55.00 refraction fee will be charged.
18. *We require a 24 hour notice of cancellation of your appointment. Anything other will be subject to a $50.00 missed appointment fee.*

X _____

PATIENT, GUARANTOR OR PERSONAL REPRESENTATIVE'S SIGNATURE ***DATE***

Your signature on this page signifies that you acknowledge and accept the above information. This also serves as an assignment of insurance benefits to be paid directly to Douglas J. Lavenburg, M.D., P.A. and/or Delmar Surgical Center, LLC.

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ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the practices Notice of Privacy Practices effective September 20, 2013.

Name (please print): _____
Signature: _____
Date: _____

I am a parent or legal guardian of _____ (patient name). I have received a copy of the practices Notice of Privacy Practices effective September 20, 2013.

Name (please print): _____
Relationship to Patient: ☐ Parent ☐ Legal Guardian
Signature: _____
Date: _____

If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices effective September 20, 2013 given to individual on _____ (date)

☐ In Person ☐ Mailing ☐ Email ☐ Other _____

Reason individual or parent/legal guardian did not sign this form:

☐ Did not want to
☐ Did not respond after more than one attempt
☐ Other _____

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

☐ In person conversation _____
☐ Telephone contact _____
☐ Mailing _____
☐ Email _____
☐ Other _____

Staff Name (please print): _____ Title: _____

Signature: _____ Date: _____

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DelMarVisionAndCosmetic.com
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Contact Lenses

The major use of contact lenses is for the correction of refractive errors. A small number of patients who meet pre-fitting criteria are unable to tolerate contact lenses regardless of fitting technique or lens type. It is important to remember that contact lenses are medical devices used to correct vision, and when used improperly, can cause permanent visual loss, especially when sleeping in them. Complications may arise with the use of contact lenses; the changes usually occur to the cornea and eyelids. Even a patient that has tolerated contacts for years may develop problems. For these reasons, yearly eye examinations are essential.

We also require all new contact lens patients, or patients new to our practice, to have a contact lens fit and evaluation, which includes a one week follow-up visit. If follow-up visits are not kept, we will not be able to order lenses or release the contact lens prescription.

Additionally, contact lens fitting and/or evaluations may not be covered by your insurance and payment in full is due at the time of service and is nonrefundable.

Financial Responsibility for Contact Lens Services

New Contact Lens Wearers:

The glasses prescription is **not** the same as the contact lens prescription. All new contact lens wearers need to schedule a contact lens fit. The price typically ranges from $90 (single vision) to $130 for more complicated fits (soft bifocal / multivision). This fitting fee is non-refundable. The fit includes an initial evaluation, a contact lens training session, and a one week contact lens evaluation (follow-up). We provide a 30 day warranty on our services pertaining to the proper fitting of contact lenses. If the contact lens evaluation (follow-up) is not completed within 30 days, an additional charge of $25.00 will be incurred.

Established Contact Lens Wearers:

If a change in fit or lens type is required, a contact lens refit evaluation will be performed. The price typically ranges from $80 for single vision and up to $130 for bifocal refits. This refit service includes the contact lens refit evaluation and a one week contact lens evaluation (follow-up) with the newer lenses.

However, if the current lenses are satisfactory with the patient and the doctor, only a contact lens evaluation fee of $55 will be charged to existing patients and $75.00 will be charged to patients new to our practice.

Contact Lens Ordering and Reordering Policy:

It is recommended that all patients being fit/refit for contacts purchase their first order from the practice.
Payment in full is required for all contact lens orders.
A fee of $20 is applied to all cancelled and returned orders, as well as a 20% restocking fee.
In the event that it is necessary to return or exchange contact lenses, unopened and boxes not written on may be returned within 30 days.

I have read, understand, and agree with the Informed Consent and Financial Responsibilities for contact lens services.

Please sign below, OR indicate "N/A" (Not Applicable) on the signature line if contact lens services are not being received.

✔

Patient, Guarantor or Personal Representative's Signature Date

Revised 07/25/12

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Dry Eye Questionnaire

Have you ever been diagnosed with Dry Eye Disease or Ocular Surface Disease? ☐ Y ☐ N

Do you have any of the following symptoms?

- ☐Blurry vision
- ☐Redness
- ☐Burning
- ☐Itching
- ☐Light sensitivity
- ☐Excess tearing/ watering eyes
- ☐Tired eyes, eye fatigue
- ☐Stringy mucus in or around the eyes
- ☐Foreign body sensation
- ☐Contact lens discomfort
- ☐Scratchy feeling of sand or grit in the eye

Have you had any of the following surgeries?

Cataract:	☐ Y	☐ N
Glaucoma:	☐ Y	☐ N
Refractive surgery:	☐ Y	☐ N

Do you use?

- ☐ Contact lenses
- ☐ OTC eye drops such as artificial tears
- ☐ Rx eye drops for Dry Eye Syndrome (*e.g.,* Restasis)
- ☐ Rx eye drops for Glaucoma (*e.g.,* Xalatan, Timolol)
- ☐ Rx eye drops for Allergy (*e.g.,* anti-inflammatory, antihistamine)
- ☐ Nutritional supplements (*e.g.,* flaxseed oil, omega-3)

Are your symptoms related to the following environmental conditions?

- ☐ Windy conditions
- ☐ Places with low humidity (*e.g.,* airplanes/hospital)
- ☐ Areas that are air conditioned/heated

Are you taking any of the following medications?

- ☐ Antihistamines/decongestants
- ☐ Antidepressant or anti-anxiety
- ☐ Oral corticosteroids
- ☐ Hormone replacement therapy or estrogen
- ☐ Antihypertensives (e.g. diruetic, beta-blocker)
- ☐ Accutane or other oral treatment for acne

Have you ever had punctal occlusion? ☐ Y ☐ N

I understand and agree that dry eye testing may be necessary depending upon the findings of my examination. I understand this lab test will be billed to my medical insurance and I may be responsible for deductibles and co-insurance, according to my insurance plan.

Patient name: _____ Date:_____

I reviewed this form and based on the information contained therein and other available clinical data, I suspect that this patient has dry eye disease and obtaining a tear osmolarity measurement is medically necessary for the diagnosis and management of this patient's ocular problem(s).

Doctor: _____ Date:_____