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Abrams Eye Institute

Authorization to release Medical Records

I hereby authorize my physician(s) and Jack Abrams, MD/Tapan Shah, MD to release any information acquired in the course of my treatment to authorized representative or entities to support claims for services or materials rendered.

This assign	nment and authorization shall be binding upor ators.	n my heirs, executors a	and
Patient Sig	nature (parent/Guardian Signature)	Date	
Office Rep	resentative Initials		
Refractio	on Fee Policy – For Eyeglasses		
glasses. W	n is the process of determining the eye's refractive will only perform this procedure if you have on for glasses is \$45.00.		
VISION te	lical insurances do not cover the cost of the rest. At Abrams Eye Institute we are a Medical Servision services.		
DESCRIPT	s, I want to have a refraction test performed to the \$45.00 Fee.	oday and understand I	am responsible
□ <mark>No</mark>	, I do not want a refraction test performed to	<mark>day</mark>	
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PLEASE NOTE: Once dilated, we will not be able to perform refraction test and you will need to schedule another visit for the refraction.

Health Insurance Benefits/Coverage/ Authorization Disclaimer

As a courtesy, Abrams Eye Institute will attempt to verify your medical health insurance benefits and or necessary authorization. Please be aware this is only "A Quote of Benefits/Authorizations." We cannot guarantee payments or verify that definite eligibility of benefits conveyed to us or to you by your carrier will be accurate or complete. Payment of benefits are subject to all terms, conditions, limitations and exclusions of the plan at the time of service.

Please note: It is your responsibility to know your insurance benefits. At the time you become a participating member of your insurance company, you are given a handbook and ID card. Every effort will be made by this office to have all service and procedures preauthorized by your health insurance company. Your insurance company will pay for services that are deemed "reasonable and medically necessary." If denied or deemed a non-covered benefit the balance becomes patient responsibility.

Abrams Eye Institute Policy

Co-pays, co-insurance, deductibles and non-covered services cannot be waived by our office, as it is a requirement placed on you by your insurance carrier. Failure to pay your portion of services rendered will be reported to your insurance company and could result in termination of your insurance plan. The Patient is responsible for all fees, regardless of insurance coverage. In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due to the doctor. A copy of the signature is as valid as the original. If you are unable to pay at the time of service your appointment may be rescheduled.

(Signature)	
Insurance Reimbursement I understand that all monies collected at the time of service provides to Abrams Eye Institute. (Initial)	ce is an estimated quote with information my insurance
	with a higher responsibility than what was quoted to me, I wince due within 30 days of notification unless other financial
·	or authorization does not guarantee of payment or to all terms, conditions, limitations and exclusions
Patient Signature (Parent or Guardian Signature)	Date
Print Name	Office Representative



Jack Abrams, MD • Tapan Shah, MD • Christopher DePalo, DO

6450 Medical Center Street, Suite 100 • Las Vegas, Nevada 89148 • Office: 702-304-9494 • Fax: 702-304-9495 1470 E. Calvada Blvd, Suite 300 • Pahrump, Nevada 89048 • Office: 775-537-2020 2451 W. Horizon Ridge Pkwy, Suite 130 • Henderson, Nevada 89052

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice. This will allow another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours notice, we are unable to offer that slot to other people.

Office appointments cancelled with less than 24 hours notification may be subject to a **\$25.00** cancellation fee. Procedure cancellations require 3 business day advance notice, without notification they will be subject to a **\$25.00** cancellation fee.

Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as "NO SHOW". Patients who "No-Show" three (3) or more times in a 12 month period, may be dismissed from the practice; thus they will be denied any future appointments. Patients may also be subject to a \$25.00 fee for office appointment "No Show" and \$25.00 procedure "No Show" fee.

The "Cancellation" and "No Show" fees are the **sole responsibility** of the patient. This fee is **not covered** by insurance, and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but **only with management approval**.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Billing Department (702-389-5862).

Please sign that you <i>have read, unders</i> t show Policy.	tand and agree to this Cancellation and No
Patient Name (Please Print)	Date of birth
Signature	