Stuart R. Winthrop, M.D.

PAYMENT & BILLING DISCLOSURE AND AGREEMENT

We will bill your insurance for you **if we have the complete information at the time of your visit,** including your social security number. If we do not have the necessary information, and/or Dr. Winthrop is not a contracted provider, we will ask that you make a full payment at the time services are rendered. If you provide the necessary information within 15 days, we will bill your insurance, and when payment is received, a reimbursement check will be issued. Please be assured that we protect your information in accordance with HIPPA Federal law.

- **Co-payments are due at the time of service.**
- **Dr. Winthrop welcomes Medicare patients. However, he does not accept Medicare assignment.** This means you'll be responsible for 20% of what Medicare allows, and any non-covered services, as well as your annual deductible. If you have a Medicare supplemental insurance, please inform us at the time of service, and we will bill the insurer for 20% of the Medicare allowable charge.
- **$60.00 Refraction charges are due at the time of service.** This is not a billable event to *most* insurance companies, therefore we ask for this payment at the time of service. If *you know* your insurance covers this expense, we will bill it, and when payment is received, a reimbursement will be sent to you.
- It is the responsibility of the patient to be **informed of the exclusions and inclusions of their insurance policy**, including, but not limited to co-pay and deductible amounts.
- If you do not have proof of insurance**, by signing this form you understand and agree that you are fully responsible for complete payment of medical fees for services provided.**
- **Dr. Winthrop is not contracted with any HMO plans or Vision Plans**. If you have either kind of insurance stated above, and you choose to see Dr. Winthrop, you are expected to pay for this visit, in full, at the time of service.
- **If Dr. Winthrop is not a contracted provider on the panel of your insurance plan,** he is not under any obligation to accept the contracted amounts as payment in full. It is your responsibility to pay for the services rendered at the time of your appointment.

PLEASE CONTINUE ON BACK ⇒⇒⇒

Stuart R. Winthrop, M.D.

PATIENT SIGNATURE

With my signature below, I acknowledge that I have read and accept all policies as described in this document.

Signature_______________________________________Date_______________

As parent or legal guardian of patient, I agree to pay for all office charges at the time of service and all outpatient charges within thirty (30) days from the time they are provided. I understand that this office bills insurance as a courtesy and that payment of all charges is my responsibility.

Signature____Date_____________
(Parent or Legal Guardian)

Please Print Name____

If you would like a copy of this sheet, please inform our office staff. Thank you.

515 E. Micheltorena St., Santa Barbara, CA 93103
Office: (805) 963-4272   LASIK Line: (805) 730-9111