

**Stephen B. Prepas, M.D. A Medical Corporation**  
**Eye Physician and Surgeon, Pediatric Ophthalmology and Strabismus**  
**360 San Miguel Ave., Suite 407**  
**Newport Beach, CA 92660**  
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**The following disclosures are made in compliance with the Federal Truth in Lending Law:**

- 1) Dr. Stephen B. Prepas will file health insurance claims as a courtesy service for those plans he is participating with. However, you are responsible for all amounts due.
- 2) For non-accepted plans, we cannot assume responsibility for collecting your claim or negotiating a settlement on a disputed claim. You are responsible for full payment on your account. We will provide you with a superbill which you can send into your insurance for processing.
- 3) Patients are responsible for knowing their insurance coverage and should refer to their plan manual for details. If your plan neither covers nor includes a service, you will be responsible for the full amount. Co-payments, deductibles and payment for non-covered services are due at the time of service. Many plans do not cover "visual related" services, even though we are a participating provider. Medicare and most insurance plans do not pay for refraction (Evaluating your present glasses or prescribing new ones). We do charge a \$40.00 refraction fee which is your responsibility at the time of service.
- 4) We accept Cash, Check and Visa (MasterCard or Visa only).
- 5) Mark one: (I authorize \_\_\_\_\_) or (I do not authorize \_\_\_\_\_) Dr. Stephen B. Prepas to furnish my insurance company all the information which may be requested.
- 6) Mark one: (I hereby assign \_\_\_\_\_) or (I do not assign \_\_\_\_\_) Dr. Stephen B. Prepas all insurance proceeds to which I am entitled for medical expenses related to the services performed from time to time, but not to exceed my indebtedness to Dr. Prepas. It is understood that any money received from my insurance company, over and above my indebtedness, will be refunded when my bill is paid in full. I understand that this assignment does not relieve me of any responsibility for charges not paid by my insurance company.
- 7) I hereby acknowledge that I am aware of Stephen B. Prepas, M.D. A Med Corp.'s Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area, and that I may have a copy of this notice at my request.

I have read and understand the above statements.

Patient's printed name	Signature	Date

Guarantor, other than patient	Relationship to patient	Date

Dr. Prepas's Representative	Date