Peter C. Brasch, M.D. LLC
1 Thurber Blvd.
Smithfield, RI 02917
(401) 349-5360 ph (401) 349-5270 fx

Dear _____

Thank you for choosing Peter C. Brasch, M.D. for your eye care. We would like to take this opportunity to welcome you as a patient and introduce you to some of our policies and procedures.

To prepare for your upcoming appointment, please complete the enclosed forms. Properly filled-out forms will help the front office staff to expedite the organization of your chart and allow you to be seen by the doctor in a timely manner. **PLEASE ARRIVE 15 MINUTES EARLY to allow the front desk to process your paperwork.**

At the time of your visit with:

Dr. Brasch on _____ at _____

Please bring the following:

- **Current insurance card(s)**
- **Photo identification**
- **A list of all medications you are currently taking, including over-the-counter medication**
- **Your eyeglasses**
- **Contact lenses with packaging or original box**
- **Your referral or authorization number *if required* by your insurance**

During your visit, you may have dilation drops placed in your eyes to help the doctor examine you. We will provide you with disposable sunglasses as you check out if you need them. If, however, you are unsure of your ability to drive when dilated, you may want to bring a driver with you.

We participate with many insurances and are happy to file a claim with your insurance for covered services. For non-covered services or products, payment is expected at the time of service. We also ask that all co-payments or co-insurance be paid at the time of service. We gladly accept credit cards (except American Express), cash, and checks. If you have any questions regarding your health insurance coverage, please contact your health insurance company prior to your visit. After your insurance pays, you will be sent a bill for the remaining balance. All patients are asked to pay this balance within 30 days of receipt of this statement. If you have questions, please contact our billing department.

Kindly give us at least a 24-hour notice if you need to cancel or reschedule your appointment so that we may offer this time to another patient. If this policy is not followed, the fee for a missed or cancelled appointment is $50 and must be paid for in full prior to scheduling another appointment.

Once again, we welcome you as a patient. We are dedicated to making your experience here a pleasant one. Please feel free to contact the office with questions you may have.

Sincerely,

Peter C. Brasch, M.D. & Staff