PATIENT FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

- As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor, in other words you agree to have your insurance pay the doctor directly. If your insurance company does not pay the practice within a reasonable length of time, (within 45 days) you may be responsible.
- **PLEASE NOTE:** We no longer bill Medical plans for refractions even if allowable.
- Your insurance policy is a contract between you and your insurance company, the doctor is not involved. We attempt to verify benefits ahead of any appointment but it is your responsibility to ensure benefits and status of policy.
- We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of service. We will collect the co-payment at the time of the service. It is your responsibility to ensure if the provider is in network or out of network.
- If you fail to notify us of an insurance change, you are fully responsible for any amount not paid by your insurance company.
- If you have insurance coverage with a plan that we do not have a prior agreement we will prepare and send the claim for you. Therefore our charges or your care and treatment are due at the time of service.
- Unless either you or your health coverage carrier have made other arrangements in advance, full payment is due at the time of service. For your convenience we will accept VISA, MasterCard & Discover.
- **Please note**-Refunds for credit card transactions will be subjected to a 3% deduction fee.
- **Please note** – Balances that are forwarded to a third party collection agency will be subject to a service fee of up to 50% of the overdue balance.
- If we receive a returned check from our bank for a payment you made, you will be invoiced for the original amount of the check plus a $25 bank fee per check. The payment of the invoiced amount will be due within 10 days of invoice date.
- We will NOT re-submit the original declined check. All amounts remaining outstanding will incur interest and/or late fees as set forth on the invoice.
- A fee of $15 will be charged for the completion of medical forms. Please allow up to 7 business days for processing.
- Amount that remain outstanding for more than 90 days will be sent to a third party for collection.
- All plans are not the same and do not cover the same services. In the event your plan determines a service to be “not covered”, you will be responsible for the complete charge.
- Some plans require a referral (i.e HMO plans). It is your responsibility to obtain the referral for your services and to ensure it was received and correct. If a referral is not obtained or is not accurate you are responsible for any amount due.
- For all services provided by our physician(s) in the hospital, we will bill your plan. Any balance due is your responsibility.
- For all services rendered to minor patients, we will hold the parent or guardian accompanying the minor responsible for expenses incurred.
- As we offer services to you, and not products, we are unfortunately unable to offer refunds on any services performed.
- In order to provide the best possible service and availability to all our patients please call us as early as possible if you know you need to reschedule your appointment. There is a late cancellation fee ($30)/ if you do not cancel or reschedule your appointment within 24 hours.
- **Please note**-If using Care Credit, a fee of up to 9.9% will be applied to the principal cost.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I hereby state that I have listed ALL the INSURANCE COVERAGE and am aware of no other insurance(s). Otherwise, I am responsible for any claims not paid because of not informing this office of all medical coverages

Name Date