Office Policies and Patient Financial Responsibilities

Our goal is to provide the best, personalized professional eye care for you and your family. We specialize comprehensive medical eye examinations and complete contact lens examinations for children, teens and adults.

Fees. Our office is committed to providing the best treatment to our patients. Our fees are representative of the usual and customary charges for the level of service provided, materials prescribed, as well as the level of advanced technology used to provide our patients with the most modern eye care in our area.

Non-Covered Services. Please be aware that some, and perhaps all, of the services you receive may be uncovered or not considered reasonable or necessary by Medicare or other medical insurers. These services may be required to be paid in full at the time of your visit or after we receive your explanation of benefits.

Refraction: Medicare and most medical insurance plans do not pay for refractions. The refraction is the "routine" test that is performed during your office visit to determine your best possible vision. A refraction is also required to determine the health of your eyes. You may be asked to pay for the refraction at the end of your visit. If we do not collect this fee at the end of your visit, you may be sent a statement after we receive your explanation of benefits (EOB) that this service was not covered. The fee for this test is $80.00.

Wellness Screening: The wellness screening is a combination of the Optomap (200-degree field of vison) retinal photo and the Zeiss Stratus ultrasound of the retina and macula and is not covered by any insurance. This screening is required on all patients in order to provide the best all-around eye care. The fee for this screening is $44.00 and is due at the time of service.

Payment. You are responsible for any co pays, co-insurance, deductible and other non-covered services. If you are a self pay patient and/or your insurance cannot be verified prior to your appointment you will be required to pay in full the day services are rendered. We accept cash, personal checks, MasterCard, Visa, Discover Card and Care Credit. If you are being seen for any ongoing medical problem, co-pays are due at each and every visit. If you foresee any payment problems, please speak to our office staff prior to your appointment.

Billing: Patients that receive a statement from our office are expected to remit full payment upon receipt unless previous payment arrangements were made with our billing office. If your account must be referred to an outside collection agency for non-payment, a fee will be added to your account to cover the expense incurred from the agency. Patients in collections must make payment arrangements prior to scheduling another appointment with our office. **If you receive a billing statement that you do not understand, please contact our office.**

Non-payment. If we do not receive payment from your insurance company within 45 days, the balance will automatically be billed to you. If your account is over 60 days past due, you will receive a letter stating that you have 21 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Delinquent accounts will be assigned to a licensed collection agency for the outstanding amount due plus a 50% collection fee. Should it be necessary to assign your account balance to a District Magistrate, subsequent legal feels will also apply. Please be aware that if a balance remains unpaid, you and your immediate family members may be discharged from the practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative eye care. During that 30-day period, our office will only be able to treat you on an emergency basis. However, this does not release you of any outstanding balances due.

Claims Filing: As a courtesy to our patients, we will file claims with insurance companies for which we are providers. We will do our best to accurately verify benefits for services and/or materials, however, **benefits quoted by your insurance carrier are not a guarantee of payment**. Any amounts not covered by insurance will be billed to the patient. Because your insurance is an agreement between you and your insurance company, we do not become involved in disputes between you and your insurance company regarding deductibles, co-payments, non-covered or denied services. When required by your insurance company, you are directly responsible for obtaining a referral from your Primary Care Physician.

Proof of Insurance. We are required by law to get an up-to-date copy of your insurance card(s) before seeing the eye doctor. If you do not present this at the time of your visit or fail to provide us with the correct insurance information, you will be responsible for the balance of the claim.

Secondary Insurances. If you have secondary medical or vision insurance, it is your responsibility to have them set up to crossover to each other. Any balance that does not automatically crossover to your secondary insurance will be your responsibility. We will provide you with an itemized receipt that you can send with a copy of your EOB (Explanation of Benefits) that you received from your primary insurance for possible reimbursement.

Missed Appointments: Once your appointment has been confirmed it will be reserved for you to meet your eye care needs. Please be courteous to our staff and fellow patients by keeping your confirmed appointment. If you are unable to keep your confirmed scheduled appointment, please inform us as soon as possible. **We do require a 24 hour notice of cancellation of your confirmed appointment. A MIMIMUM FEE OF $50.00** may be charged to your account for broken appointments based on the amount of time and service reserved for you. If you do not cancel 24 hours in advance or no-show for your scheduled appointment 2 times in a 12-month period, you will be dismissed from our care.

Authorization: I authorize Premier Eye Center to act as my agent in applying for insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Premier Eye Center on my behalf. I authorize any holder of medical information about me to release information needed to determine benefits payable for related services. If I have additional insurance, my signature authorizes release of the above medical information to any insurer or agency I have given, and authorize my doctor to act as my agent above.

Consent to Treat. I request and give consent to Premier Eye Center to provide and perform such medical and vision eye care, tests, procedures, medications and other services and supplies as are considered medically necessary or beneficial for my eye and vision health, and well-being.

****** Initial_____ (Effective for one year)**

Billing Questions: All questions regarding insurance, billing and balances will be directed to the staff and <u>not the doctor</u>.

****** Initial_____**

With my signature below I confirm that I have been informed of and agree with the above outlined policies and insurance authorization and that I have received a copy of Premier Eye Center, P.C.'s Office Policies and Patient Financial Responsibilities. Unless revoked by me in writing, this authorization is effective for one year.

SIGNATURE: _____ (Patient or Responsible Party) DATE: _____