General Information

Thank you for allowing us to participate in your eye care. If you have insurance, we are committed to helping you receive your maximum allowable benefits. We understand that the insurance field can be quite confusing. Our financial policy is provided to assist you in understanding your responsibility to both The Eye Clinic Inc. and your insurance carrier. **Ultimately, all financial liability rests with the patient**. This includes but is not limited to routine vision exam, special testing or procedures such as OCT, HRT, Visual Field, Fundus Photography, Pachymetry, Topography, Ultrasound, Gonioscopy, Punctal Plug Insertion, or External Photos. Our technicians are able to explain any test or procedure that has been scheduled for you.

When you come to The Eye Clinic Inc. for your appointment, you will be asked to provide us with a photo ID and your insurance card. We will scan your insurance card for our records. You will also be asked to verify your address, telephone number, and insurance information. Please bring a full list of your current medications including dosages.

Patient Financial Policy

Refraction and Contact Lens exam & fee: A refraction is the process of determining your best-corrected vision. It is an essential part of an eye examination and is necessary to write a prescription for glasses or contact lenses. Our fee for the refraction is $28.00. The fee for a contact lens evaluation/ fitting may vary due to the complexity of the fitting and type of contact lenses. The refraction and contact lens evaluation/fittings are not a covered benefit by most insurance companies, including Medicare.

Insurance: Your insurance policy is a contract between you and your insurance company. As medical providers, our relationship is with you and not your insurance company. While the filing of insurance claim forms is a courtesy we extend to our patients, any unpaid charges are your responsibility. You are expected to know and follow all regulations as agreed to by you and your insurance company regarding referrals, second opinions or pre-certifications. **Any out of pocket expenses such as co-pays, coinsurance and deductible must be paid at the time of service.** Failure to provide copies of insurance cards may result in denial of your claim, and you will be held responsible for the balance. **If you have a managed care plan that requires a referral to see a specialist, you must obtain a referral in order for your visit to be covered. If you do not have a valid referral, you will be asked to pay for the visit prior to your examination.**

Supplemental insurance: If you have supplemental insurance, we will send a claim to that company as a courtesy. Your signature on this form authorizes The Eye Clinic Inc. to bill and receive payment from your insurance company.

Worker's Compensation: In order for us to file a claim with Worker's Compensation, you must fill out all required paperwork which is available at our reception desk. We must have adequate information to bill either you MCO or Self-Insured plan. If you do not have this information available when you come in for your appointment, you will be responsible for all charges incurred until we receive this information from you.

Motor Vehicle Accidents: If you are involved in a motor vehicle accident, and you receive treatment from The Eye Clinic Inc., you will be responsible for payment of all charges incurred. We will provide you with a statement which you can turn into your medical or auto insurance carrier for reimbursement
No Insurance: Payment in full is due at the time of service
Methods of payment: We accept cash, check, Visa, MasterCard and Discover
NSF Checks: Any check that does not clear your bank account will result in a $25.00 fee
Refunds: If an overpayment has been made, a refund check will be issued to you. Overpayments for $5.00 or less will be credited to your account.
Statements: If there is a balance on your account after filing your insurance carrier, you will receive a statement. Payment is expected **by the due date** on your statement. If you have any questions regarding your statement, please contact the Billing department immediately. Your account will be considered delinquent after 30 days from your first statement. **Any debt old or new is expected to be satisfied to continue services with The Eye Clinic Inc. Failure to do so may result in dismissal.**

Services rendered to minor/dependent patients: For services rendered to minor patients, the parent(s) or guardian(s) of the minor are responsible for payment**.**

I have read and understand the financial policy of The Eye Clinic Inc. regarding payments and insurance. I agree to pay for services and tests not covered by my insurance plan. I also understand that I am responsible for following my insurance plan's regulation, policies and procedures. I addition, I understand that my signature authorizes the The Eye Clinic Inc. to discuss my medical or other relevant information with my attending physician or my insurance carrier as needed.

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Patient signature/Guarantors Signature

Please state relationship to patient if you are signing on their behalf

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Date________________________________