THE EYE CENTER

# FINANCIAL POLICY

## OUR FEES AND PAYMENT POLICY

We are here to provide you with the eye care you need. This explanation of our payment policies has been prepared so that you can help us maintain quality services. Our payment policies are designed to enable us to reduce unnecessary collection costs which would otherwise increase the cost to our patients.

We know that insurance costs are confusing to everyone. However, by understanding your insurance plan and our policies, you will avoid surprises regarding payment obligations. Please refer any questions at our office to our billing specialists. We will be more than happy to assist with your concerns.

## YOUR RESPONSIBILITY FOR CHARGES

You are ultimately responsible for the payment of services you receive. We rely on the accuracy of information you provide to determine if a third party will be responsible for payment. **If you will be paying for services, or if you are responsible for a deductible or co-payment, we expect payment at the time services are rendered.** You can request verification of benefits if you are unsure of coverage. However, this request will need to be made a week in advance of your appointment. We accept cash, personal checks, VISA, MasterCard, Discover and American Express.

If payment is to be made through an insurance or medical plan that we have an agreed assignment with, then you are responsible for complying with all procedures required by that plan to enable us to receive payment on your behalf. To verify your insurance benefits, we may ask to confirm information and check eligibility prior to appointment date.

You are responsible for payment of any non-covered services by your insurance plans. If a patient is put in collections for non-payment, there is an additional collection fee of $30.00.

## MEDICAL OR VISION SERVICES

Insurance Plans differentiate between “medical” and “vision” problems. Most medical insurance plans do not pay for “vision” services. Most vision plans do not pay for “medical” conditions. While some medical problems are obvious, when you have an eye problem, it may be almost impossible for you to know if it is a “vision” or “medical” problem. If you have a medical problem, we can file a claim with your medical plan. If you simply need an eye exam for glasses or contacts, this is usually a “vision” service. It would be covered if you have a “vision” rider or separate vision plan.

## INSURANCE PLANS

Your insurance company determines what they will or will not pay for. We rely on what an insurance company representative tells us to make an initial determination of coverage. Subsequent decisions are made by your insurance company. **If you do not have insurance coverage we expect full payment from you at the time services are rendered.**

In order for our services to be covered under your plan, you must comply with your plan's requirements. If a written referral plan is required by your plan, you must provide such referral before the service is provided. If you do not have a valid referral form at the time of your visit. Co-payments must be paid at the time of service.

REFRACTION SERVICE AND FEE

Refraction is the process of determining if there is a need for corrective eyeglasses. It is necessary to write a prescription. It is not covered by Medicare or most insurance plans. It is considered a "vision" service, not a "medical" service but is also used for diagnostic purposes. Our office refraction fee is currently $30.00. This fee is collected at the time of service. Should your plan pay us for the refraction, we will reimburse you accordingly.

CONTACT LENS EVALUATION AND FEE

Please refer to the next page regarding our contact lens policy. This policy goes over the details on evaluation, insertion and removal training and recheck fees.

OVERPAYMENTS

Overpayments are assessed monthly after your insurance responds to the claim. Any necessary refunds will be sent to the address we have on record.

MEDICARE ASSIGNMENT/PROMISE TO PAY

I request that payment of authorized Medicare and/or insurance benefits be made to The Eye Center on my behalf for any services and furnished to me. I authorize any holder of medical information about me to be released to the insurance carrier, any information needed to determine the benefits payable of related services.

This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

# CONTACT LENS POLICY

A contact lens vision exam is a routine eye exam for contact lens wearers or patients who want to become contact lens wearers. This exam is to address your vision needs and includes the exam plus the evaluation, fitting and 30 days of follow-ups for your contact lenses, contact lens prescription, and trials if applicable. This will be filed to your vision insurance and you will be responsible for copays and any additional fees non-covered by your individual plan.

Follow ups may be necessary to check and adjust the material power or other factors. Your contact lenses must be worn to this appointment so adjustments can be made if needed. Follow ups within the first 30 days of your exam are included in the fitting charge.

If you are a **new contact lens wearer**, you will be trained to insert, remove, and properly care for your contact lenses.

Additional fees associated with contact lenses are as follows:

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| • Contact lens exam fees (prescription of, fitting, and medical supervision of adaptation; corneal lenses) | $40.00 (may be filed to your insurance) |
| • Insertion and removal training (required for new wearers) | $35.00 |
| • Follow up visits greater than 30 days after your contact lens exam | $30.00 per visit |

Contact lenses can be ordered conveniently through our contact lens department. All contact lenses must be paid in full upon order and many times, can be shipped directly to your home.

# ACKNOWLEDGEMENT OF FINANCIAL POLICY

I acknowledge that I have received The Eye Center's Financial Policy. I have read and understand the Financial Policy and I agree to abide by the terms and conditions.

Patient Name: _____

Date: _____

Financially Responsible Party: _____

Financially Responsible Party Signature: _____