**THE EYE INSTITUTE**

FINANCIAL POLICY

*We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your assistance and understanding of our payment policy is necessary, as all financial liability ultimately rests with the patient. Please ask if you have any questions about our fees, financial policy or your financial responsibilities. patients must fill out patient information and financial forms prior to seeing the doctor.*

**Self-pay patients are required to make full payment up front at the time of your visit.**

* **CO-PAYMENTS—**By law we MUST collect your carrier-designated copay at the time of service. Please be prepared to pay your CoPay at each visit.
* **HMO AND MANAGED CARE PLANS—**COPAYMENTS are due at the time of your appointment. Patients are responsible to pay ANNUAL DEDUCTIBLE AND COINSURANCE, if applied by your insurance policy. If a • ***REFERRAL*** is required from your primary care physician, it is your responsibility to obtain it prior to your appointment**. If you do not have your referral, you will need to reschedule your appointment**. Your type of insurance does not allow us to make any exceptions.
* **MEDICARE—**Our office will submit a claim to Medicare for your office visit. You will be responsible for 20% coinsurance and applicable deductible, which can be billed to a secondary insurance, if you have one. Please note that the refraction is a non-covered service, according to Medicare regulations. For any questions about the non-covered refraction, please call Medicare.
* **NON-PARTICIPATING INSURANCE AND UNINSURED PATIENTS—**Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. Your itemized receipt should be attached to your insurance form and sent to your carrier, who will reimburse you directly.
* **REFRACTIONS—**Medicare and many other medical insurance plans do not cover the refraction fee. Payment for refractions are expected at the time of service. Our fee for the refraction is $55.
* **CONTACT** **LENSES--**Payment is expected at the time an order is placed or when it is picked up.
* **RETURNED CHECKS—**Any check payments that do not clear the bank will be subject to a $45.00 returned check fee.
* **CANCELLATION POLICY—**We require **24 hours notice** for an appointment cancellation, otherwise, we reserve the right to charge a $75 cancellation fee.
* **WORKERS COMPENSATION--**You are responsible for promptly submitting our bill to your employer. You will be responsible for any bills not paid in full within thirty (30) days.
* **MOTOR VEHICLE ACCIDENT—**It is your responsibility to submit bills to your auto insurance company. You are responsible for any deductibles or copayments. You will be responsible for any bills that are not paid in full within thirty (30) days.
* **SURGERY—**Our physician fees for surgery and hospital visits will be billed directly to your insurance company. You are responsible for any non-covered fees. Our fees do not include charges for the surgi-center or hospital-dispensed medications, or another physician’s fees.
* **RESPONSIBLE PARENT**—In the case of divorced or separated parents, our policy is that the parent bringing the child into our office is responsible for the full payment of out-of-pocket fees at the time of service.

I instruct and direct Medicare and/or my insurance company(s) make payment on my behalf to The Eye Institute for any services provided by them to me or my dependents for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. I HAVE AGREED TO PAY ANY BALANCE OF PROFESSIONAL SERVICES CHARGES OVER AND ABOVE THIS INSURANCE PAYMENT. I authorize any holder of medical information about me to release, in writing, electronically or verbally over the telephone, to my Insurance Company, its agents or any other carrier I may have, and to request any information needed to determine these benefits or the benefits payable for related services on my behalf. I understand and agree that, regardless of my insurance status, I am ultimately responsible for all charges for professional services rendered to me, or my dependents. I agree to also reimburse The Eye Institute for any attorney’s fees, legal and other costs incurred in collecting any balance that I owe. I hereby authorize The Eye Institute to initiate an appeal to my insurance company, or their agents on my behalf. I hereby authorize The Eye Institute to initiate a complaint to the Insurance Commissioner of any state for any reason on my behalf.

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Responsible Party Signature Print Name Date mulanet/2019eaw/forms/financialpolicy