OPHTHALMOLOGY ASSOCIATES

It's a beautiful world. See it well.

PATIENT FINANCIAL AGREEMENT & ACKNOWLEDGEMENT OF OFFICE POLICIES

Ophthalmology Associates believes that part of good health care practice is to establish and communicate an office and financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to have a full understanding of our policies.

1. **PAYMENT** is expected at the time of your visit. We accept cash, check, Visa, Mastercard, Discover, and Care Credit on select procedures. Payment will include any unmet deductible, co-insurance, co-payment amount, charges not covered by your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. All non-filed services are expected to be paid at the time of service.
2. **INSURANCE:** We are participating providers with most insurance plans. We will file all of the claims for these plans. **Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. As a courtesy to our patients, we will verify your insurance coverage, however, our verification is not a guarantee of benefits payable by your insurance. 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 in our office to be covered under your medical insurance.** If you do not have the valid referral and still wish to be seen, you will be asked to pay for the visit prior to your services. **In order to bill your insurance and to meet filing guidelines we do ask for a copy of your insurance card and a photo ID.**
   If our providers are not listed in your plan's network, you may be responsible for partial or full payment.
3. **POLICY ON NON-COVERED SERVICES:** This office offers access to many innovative services and procedures some of them are deemed as "not covered" by insurance. In some cases, you will be given an ABN (Advanced Beneficiary Notice) for these types of services/procedures before they are provided/performed. You will be responsible for payment in full at the time of service.
   a. **Refractions - A refractive examination is not a covered service by most insurance companies, including Medicare. If you receive a refraction, you will be charged $47.00 which is payable at the time of the visit.**
   b. **Contact Lens Fitting –** In order to receive a contact lens prescription, a contact lens fitting must be performed. There will be a separate charge for the fitting which may or may not be covered by insurance. Based on your benefits, you will be required to pay for your fitting in full before receiving your contact lens prescription.
4. **RETURNED CHECKS** will incur a $50.00 service charge.
5. **FORMS FEES:**
   a. **Medical record copies** – Medical record copy requests made by the patient for their personal use, for an insurance company, an attorney, etc., will incur a copying fee, as directed by the state statute and are as follows, following the completion of a release of medical records form:
      $25.00 for the first 20 pages
      $.15 per page for additional pages over 20
      $25.00 for Billing Records
      There is no charge for records being released to another physician.
   b. **Forms Completion –** Forms may be dropped off and we will call when they are ready to be picked, or we will send to appropriate designee. Fees for form completion are as follows:
      $15.00 for Affidavit
      $8.00 for films/photos
      $18.00 for Government/Disability forms

6. **RESPONSIBILITY FOR PAYMENT:** I understand that I, personally, am financially responsible to Ophthalmology Associates for charges not covered by the assignment of insurance benefits and all non-covered charges.
7. **AUTHORIZATION & ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize Ophthalmology Associates to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to Ophthalmology Associates all payments otherwise payable to me for Ophthalmology Associates services.
8. **CONSENT AND DISCLOSURES:** I voluntarily consent to medical treatment for myself and/or my dependents.
9. **RELEASE OF INFORMATION:** I hereby authorize and direct Ophthalmology Associates to release (verbally or in writing) confidential medical information to any person, entity, government agencies, insurance carriers, or others who are financially liable to Ophthalmology Associates for charges for medical treatment, and for quality management, utilization review, transfer of medical care, and follow up purposes. I understand that a copy of this document may be used with the same effectiveness as an original.
10. **SELF PAY PATIENTS WHO ARE INSURED:**
    Self-pay patients will be identified when they make the initial contact with the office and will be defined as a patient who
    - has no health insurance coverage of any kind, including federal and state health care programs such as Medicare and Medicaid or other insurance coverage such as insurance provided by a school, or AFLAC
    - does not claim third party liability for the patient's health care treatment
    - is not eligible for worker's compensation coverage; and
    - has no other responsible party covering the expenses associated with the care received from our clinics

    Self-pay patients will be required to pay a $125.00 deposit for their visit at time of check in. Any additional charges incurred will be collected at check out. All charges are due on the date of service.
11. **BILLING AND COLLECTION FEES:** Ophthalmology Associates will submit a claim for payment to your insurance company. In the event your insurance carrier/company denies the services provided, you will be responsible for the payment in full. We appreciate prompt payment in full for any outstanding balance. **If your account is turned over to our collection agency, you agree to pay an additional $50.00 fee to cover the fees imposed to Ophthalmology Associates by the collection agency in order to collect the outstanding balance.**
12. **DIVORCED PARENTS OF PATIENTS:** By signing below, the adult who signs in a minor child to our practice on the day of service accepts full responsibility for payment. It is not our policy to send bills or records to the other parent/guardian for issue of payment or communication. We will communicate about treatment and payment with the parent present at the time of visit. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.
13. **NO SHOW POLICY:** We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide more than a 24-hour notice. Patients who do not show up nor provide more than a 24-hour notice are considered a NO SHOW. **Patients who No-Show two (2) or more times in a 12-month period, may be dismissed from the practice.**

I have read and understand the practice's office and financial policies and I agree to be bound by its terms.

I also understand and agree that such terms may be amended by the practice at any time.

Signature of Patient/Guarantor, if applicable Date

Disclaimer: Ophthalmology Associates does not consider an individual seeking treatment to be a patient until a preliminary assessment is completed and the individual has been notified that he or she has been accepted as a patient; simply making an appointment does not automatically initiate doctor-patient relationship.