PATIENT FINANCIAL RESPONSIBILITY POLICY

Patient Name: _____ DOB: _____

Insured Name: _____ DOB: _____

Address Change

- It is important that we have your correct address information on file. Please advise us anytime there is any change to your address, telephone or other contact information.

Co-payments, Deductibles and Co-Insurance

- Co-payments are collected at the time of check-in.
- Insurance deductibles and fees for services not covered by your insurance policy, if known, are due at the time the service is rendered. We accept cash, check and most major credit cards.

Billing

- If you owe additional money after your visit, you can expect to receive a statement. Statements are mailed out on a monthly basis.

Failure to Pay

- Patients who ignore collection notices and fail to pay their balance risk negative credit ratings and possible dismissal from the practice.
- Past Due accounts may hinder your ability to have appointments scheduled.

Self -Pay Patients

- Self- pay patients should be prepared to pay at the time of each visit.

Fees

- Returned checks are subject to a $32 fee and your account will be placed on a "cash-only basis." We will accept payments only by cash or credit card until the balance is cleared.
- Failure to give 24 hours cancellation notice or failure to keep your scheduled appointment may result in a charge of $30. Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. We reserve the right to charge a fee for canceled or missed appointments. If you must cancel an appointment, Vision Park requires a minimum of 24 hours notice.

Guarantor

- Any patient over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred. If another party is responsible for payment of your account, you must pay your balance in full and negotiate repayment with them outside of our office. This policy includes individuals negotiating divorce agreements.

Referrals and Authorizations

- Please be aware of and provide any required referrals or authorizations in advance of the appointment of service. If you do not provide these before care is provided, you will be responsible for the cost of the care. When in doubt contact your plan directly for clarification.

Medicare Patients

- Medicare may not cover some of the services that your doctor recommends. You will be informed ahead of time and given an Advanced Beneficiary Notice (ABN) to read and sign. The ABN will help you decide whether you want to receive services, knowing you are responsible for payment. You must read the ABN carefully.

Refunds

- A refund is issued when an overpayment has been identified. If you feel a refund is due, please contact our billing office.

Worker's Compensation

- The patient must provide at time of service: a claim number, name of the carrier, the date of injury, employer at time of injury and name and number of the claim adjuster. Without this information, the patient will be held responsible for all charges, and payment will be collected at time of service.

Insurance

- It is important for you to be an informed consumer, who understands the specifications of your insurance policy (eg, routine vision coverage, vision therapy coverage and referral/authorization requirements). Your health insurance policy is a contract between you and your Health Insurance Company or employer. Please note it is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorizations and limits on outpatient charges regardless of whether or not our physicians participate.
- You must present a current insurance card at each visit. As a courtesy to you, we will bill your insurance company directly for services rendered. If problems arise regarding coverage issues, we will attempt to work with your insurance company to help resolve them prior to making it your responsibility. However, please be advised that you are nevertheless ultimately financially responsible for payment of services rendered by this office.
- If you do not present a current insurance card, you will be responsible for payment at the time of your visit. You will receive reimbursement from Vision Park if your insurance pays the claim at a later date.
- If your insurance carrier is not one with which we participate, you are responsible for payment in full. Insurance plans and Medicare consider some services to be "non-covered," such as a routine vision exam, and/or refractions, in which case you are responsible for payment in full.
- Insurers are required to pay a properly submitted claim within 30 days. You have a responsibility to provide information to our office so a claim can be properly submitted. If your insurance company has not paid a claim on your behalf within 90 days, the balance will be transferred to your account and you will be responsible for payment. If we receive payment at a later date, you will be reimbursed.
- If you are uncertain about your current health insurance policy benefits you should contact your plan to learn the details about your benefits, out-of-pocket fees and coverage limits.
- Our doctors belong to many insurance plans. Before your appointment, please be sure your doctor is in-network and the services are covered under your plan. If your doctor is out-of-network, you will be billed for the cost of care.
- If we contact your insurance carrier regarding benefits or authorization on your behalf, we are not responsible for inaccurate information provided to us by your carrier. The information about your plan that we relay to you is in good faith.

I authorize covered benefits to be paid directly to Vision Park Family Eye Care. I have been advised that my insurance may or may not fully cover the exam, refraction, vision therapy, low vision training/aids or materials for glasses or contact lenses. Although my insurance may deny coverage of these procedures, I have advised the doctor to proceed with any of the services deemed necessary and I will assume full responsibility for payment. I will pay any service charges applied to my outstanding balance after 30 days. The rate of said service charge is 1.65% per month on all balances (19.8% per year). The minimum monthly service charge is $.50.

_____ _____

Patient or Guardian Signature Date