

**Financial Policy**

Welcome and thank you for choosing Optomedica Eye Consultants for your medical care.

We are committed to providing you with quality medical care, our professionals fees have been determined through careful consideration, and we believe these fees are reasonable and reflect other area physician charges. We are pleased to discuss with you any questions you may have concerning your bill. Providing quality care is our primary concern.

Regarding Insurance

Indemnity and Private Insurance Policies: Optomedica Eye Consultants will file claims directly with your insurance carrier for services where covered benefits have been verified. Insurance verification does not guarantee your insurance will pay for services. Payment of co-insurance, co-pays, deductibles or fees for non-covered services, when applicable, is required at the time of service.

Contracted Managed care Plans (HMO,PPO,POS,EPO, etc.): Each time you make an appointment with Optomedica Eye Consultants, it is your responsibility to make sure the physician is currently under contract with your plan and you have obtained the necessary referrals when needed. Verification of your plan benefits/coverage is required. Often this verification requires us to share the reason for your visit with a managed care plan. Payment of co-insurance, co-pays, deductibles or fees for non-covered services, when applicable, is required at the time of service.

We allow 45 days from the date of claim was filed by our office for the insurance company to pay. If the insurance carrier has not paid within this time, you are responsible for the entire balance without further notice. We will not become involved with disputes between you and your insurance company regarding deductibles, non-covered services, co-insurance, copayments, coordination of benefits, pre-existing conditions or "reasonable and customary" charges other than to supply factual information when necessary. You are responsible for the timely payment of your account.

Medicare: Optomedica Eye Consultants accepts assignment for Medicare benefits. However, you may be asked to sign a waiver to acknowledge your understanding of your responsibility to pay for services not covered by Medicare.

Method of Payment: For your convenience, Optomedica Eye Consultants will be happy to accept your Visa, Master Card, Discovery, and cash for payment of your medical services. A \$25.00 fee will be accessed to your account for all returned checks. For convenience, CareCredit is also available.

Minors: The Parent(s) or Guardian(s) of a minor are responsible for providing current insurance information for the minor and/or payment in full services provided. Unaccompanied minors must have authorization for medical treatment signed by a parent or guardian and is responsible for current insurance information for self and/or payment in full for services provided.

To assist us in updating your Optomedica Eye Consultants financial account, please (1) provide current patient and insurance information and (2) authorize release of information necessary for insurance filing and precertification by signing the statement below.

I have read and understand the above terms and conditions and will verify so by giving my Signature.

Signature

Date

I acknowledge that I have received a copy of Optomedica Eye Consultants "Notice of privacy Practices".

Signature

Date

Insurances assignment and Authorization to Release information

I request Payment of authorization Medicare/Other Insurance company benefits be made on my behalf to Optomedica Eye Consultants for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare Assignment of Benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare/Other Insurance company claim. Permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the above-mentioned party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C 3801-3812 provides penalties for withholding this information).

Signature

Date

Statement of Coverage: I hereby attest that I do not have additional health care coverage afforded to me other than the primary insurance supplied by myself or legal guardian at the time of my appointment.

Signature

Date