Dr. Adriana Palumbo's Office Financial Policy
We are dedicated to providing you with the best possible care.

<u>Uninsured Patients</u>: Full payment is due at the time services are rendered, unless other arrangements have been previously approved.

<u>Insured Patients</u>:
We need your assistance and understanding of our payment policy to help you receive maximum allowable benefits. We will gladly discuss any questions related to our fees. Your insurance is a contract between you, the patient, and your insurance company. If you are not sure your plan covers routine vision, payment is due the date of the service and you are responsible for submitting on your own for reimbursement.

- Deductible is the patient's responsibility**;** even **MEDICARE has a deductible**
- It is the patient's responsibility to know if you have a deductible and if you have met it for the year
- Co-Insurance/Co-Payments are the patient's responsibility
- **Referrals, if required, are the patient's responsibility. YOU WILL NOT BE SEEN IF YOU DO NOT HAVE THE PROPER REFERRAL UNLESS PAYMENT IS RECEIVED IN FULL UPFRONT.**
- Filing insurance claims is a service provided without charge and in NO WAY RELIEVES you of the responsibility of your bill.

EXAMPLE: if your insurance pays 80% of covered/discounted charges, the patient responsibility will be 20% of covered/discounted charges. The 20% is called **CO-INSURANCE**.

If you have a secondary insurance, please let us know if you have an automatic crossover. If you do not have automatic crossover you will be responsible for submitting a claim for reimbursement. **If you're secondary insurance does NOT cover your 20% co-insurance, YOU WILL BE RESPONSIBLE FOR THE 20% co-insurance.**

Your insurance company states these are the patient's responsibility and payment is due when:

- Charges are applied to your DEDUCTIBLE
- Charges are applied to your CO-INSURANCE
- If you do not reply to your insurance company's requests for further information required to process your claim
- If insurance payments are sent directly to you, you are responsible to send them to our office along with the EOB (Explanation of Benefits)

If you insurance company does not pay your bill within 60 days from the date it is submitted, you will be asked to pay the balance in full or to set up a payment plan to begin reducing your entire balance.

<u>Medicare Patients</u>: **The refraction part of the exam determines your eyewear prescription.** Medicare does not pay for this portion of the exam. Therefore, the $40 refraction charge is the patient's responsibility and due at the time of service. You are responsible for your annual deductible and the 20% co-insurance. At the time of each visit we will electronically process an insurance claim form with Medicare for reimbursement of services rendered. We are participating specialists in Medicare so we will gladly await payment from your secondary insurance carrier if you have one. If you do not have a secondary insurance carrier, or they do not pay, your 20% co-insurance is due to be paid after Medicare has paid its portion.

Dr. Adriana Palumbo's Office Financial Policy (cont'd)

Medically Submitted Exams: Should your exam be submitted with a medical diagnosis, there will be a refraction charge of $40.00 plus any insurance co-payment or deductible. **If your plan requires a referral from your primary care doctor, you are responsible for obtaining it PRIOR TO YOUR APPOINTMENT**. In the absence of a referral, you will be responsible for the full charges that must be paid at the time of the visit. At the time of each visit we will process a completed insurance claim form to your insurance carrier for reimbursement. If your insurance denies the claim, the charges incurred are your responsibility.

Patients with VSP/EyeMed/Routine Vision coverage: This insurance coverage is for examinations related to eyeglasses and or contact lenses. It does NOT cover ANY MEDICAL TESTING. If you have high blood pressure, glaucoma, diabetes, headaches, take cholesterol medication, seeing floaters, etc. you WILL REQUIRE FURTHER TESTING. This testing will be billed to your MEDICAL INSURANCE carrier. ALL DEDUCTIBLES and CO-PAYS WILL APPLY to the procedures necessary for the health of your eyes. If your plan REQUIRES A REFERRAL FROM your primary care doctor, YOU ARE RESPONSIBLE for letting the staff know BEFORE the testing is done and to obtain the referral for the required testing. In the absence of a referral, you will be responsible for full payment that must be paid at the time of the visit.

Contact Lens Wearers: Most insurance companies **DO NOT** pay for contact lens related services. If you are presently wearing contact lenses and wish to renew your prescription, it is necessary to make sure the fit; corneal health, vision, and cleanliness of the contacts are in order. These procedures are **NOT** covered by your insurance and the fee is $70, due at the time of service. This pricing does not reflect VSP or EyeMed coverage. This pricing is individually dictated by your VSP and EyeMed carrier, we do not have control over these prices.

First Time Contact Lens Wearers: There will be fees related to fitting the contact lenses and subsequent visits involved in our program. These visits are to ensure your cornea remains healthy, the contact lenses fit properly and to answer any of your concerns. These fees vary depending on the complexity of your case and will be discussed with you **before** any services are provided.

I understand and agree that, regardless of my insurance status, I am responsible for all charges for services rendered to myself, or dependent. I have read the information above and verify that all insurance information is true and correct to the best of my knowledge. I give permission to the office of Dr. Adriana Palumbo to release any of my or my dependent's information and records to my insurance company. I also request payment of government benefits or Medicare benefits either to Dr. Adriana Palumbo or to the party who accepts assignment of my insurance claim. I authorize payment of medical benefits to my physician for the services described on the insurance claim form. *I hereby authorize Dr. Adriana Palumbo to release such information as required by my attorney and/or insurance company to secure my insurance benefits.* ***I understand and agree that I am ultimately responsible for the balance of my account for any professional services rendered. If my failure to pay for said services necessitates legal action, I will be responsible for legal fees, interest and cost of suit. In cases of divorced or separated parents, our policy is that the parent bringing the child into our office is responsible for payment of all fees.***

I have read all of the information above and my signature below is acceptance of these terms. An adult signature is required for any minor patient.

Insured Name: ____ **Date of Birth:** ________________________

Relationship: _______________________

Patient Name (printed): _________________________________

Signature: ____ **Date:** ___________________