Pine Eye Associates
Patient Financial Policy

Thank you for choosing Pine Eye Associates as your health care provider. We are committed to building a successful provider-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities.

Insurance Card
It is your responsibility to provide us with current insurance information. If we do not receive current information at the time of service, it will become your responsibility to pay for services until current information is provided to us. If correct insurance information is not provided within 30 days of services rendered, you are financially responsible for the entire bill.

Vision Insurance
Some group policies contract vision benefits to another insurance carrier different from your major medical insurance carrier. It is your responsibility to know if you have vision insurance that may cover your routine eye exam services or eyewear purchases and you must notify us at the time of service. ****It is your responsibility to know if we are in your vision insurance network before services are provided. Please note: Vision insurance cannot be billed for medical services or treatment****

Insurance Claims
Insurance is a contract between you and your insurance company. <u>We will bill your insurance company as a courtesy to you, but we are not responsible for knowing what is covered by your insurance company</u>. You must have a current *coordination of benefits* with your insurance company or companies.

**** **coordination** of benefits—ensure your insurance company or companies are informed about your various policies so each insurance processes your claim(s) correctly and all insurance update requests have been completed. We will not submit claims multiple times due to a lack of coordination of benefits.*

<u>If you would like us to submit your claim to more than one insurance company, you must notify us as to which insurance is primary, secondary, and tertiary (if applicable).</u> Failure to provide complete and accurate insurance information may result in your responsibility for the entire bill.

Co-pays & Outstanding Balances
All co-payments and outstanding balances are due at time of check-in unless previous arrangements have been made with us. All past due balances will accrue finance charges after 60 days which you are financially responsible for. If no payment attempt is made with our billing office, or you fail to meet payment arrangements, your account will be sent to a collection agency or attorney, and you may be discharged from our practice. We accept cash, check or credit cards.

Self-pay Accounts & Liability Cases
You will be considered a "private-pay" account if you do not have insurance coverage, <u>your insurance plan does not participate with this office</u>, or if <u>we do not have your valid insurance card on file with us</u>. In other words, you will be responsible for the entire bill. Also, if the information we have for you is not acceptable to your insurance company, and you fail to update that information, you will be considered private-pay. Liability cases will also be considered private-pay accounts. We do not accept attorney letters or contingency payments.

No-Show / Cancelled Appointments
If you do not cancel an appointment at least 24 hours in advance you will be charged a $40 no-show/cancellation fee per appointment. Saturday appointments require 48 hour notice.

Products, Contact Lenses & Frames
We require half down of the total balance to order with the remaining balance due at the time of dispense. Additionally, other outstanding balances on account must be paid in full before eyewear products are dispensed. If redeeming vision insurance, the *estimated* patient's cost for eyewear must be paid in full at the time of order. Dispensed frames, lenses that are already started by the lab, and dispensed boxes/vials of contact lenses are not returnable or exchangeable. PD measurements are not released.

Follow-Up Prescription Rechecks/Changes
A minimum fee of at least $45 will be charged for any prescription rechecks regarding difficulties with eyewear purchased outside of the clinic. A one-time doctor's change to spectacle lenses purchased from our clinic may be allowed within 90 days of original prescription. (NOTE: This is not 90 days from spectacle lens order.) Contact lens follow-up exams are limited to two and must occur within 60 days of original contact lens fitting. Additional visits and trial contacts will incur a fee.

Referrals, Preauthorization & In-Network/Out-of-Network
If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain this may result in a lower or non-payment from your insurance company, and the balance will be your responsibility. Furthermore you are responsible to know if we are a part of your insurance network. If we are out-of-network and you seek treatment, we are happy to submit a claim on your behalf, but if your insurance payment is reduced or denied due to network issues, you are financially responsible.

Workers' Compensation & Automobile Accidents
In the case of a workers' compensation injury or automobile accident, you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier prior to your visit. If this information is not provided, you will be asked to reschedule your appointment or pay for your services at the time of visit. In the case of automobile accidents, if your auto insurance carrier has not paid within 45 days, we will bill your health insurance. You are financially responsible if payment is not made.

Minors
The responsibility for payment for services rendered to the child/children of divorced or separated parents rests with the parent who seeks treatment. Any court ordered judgment must be between the individuals involved, without including our facility.

Returned & Stop Payment Checks
The charge for a returned or stop-payment check is $30 which will be applied to your account in addition to the insufficient funds.

I have read Pine Eye Associate's Financial Policy, agree to the terms stated, and understand my financial responsibility to my healthcare provider. **I have also been given or offered a copy of this policy. Furthermore, I have requested Pine Eye Associates to bill the listed insurance company or companies on my behalf for services provided.**

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Patient Name
1)________________ 2)________________
Primary Insurance Secondary -if applicable

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Patient Signature *(or Parent or Guardian if Minor)*

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Date

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Patient Name
1)________________ 2)________________
Primary Insurance Secondary -if applicable

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Patient Signature *(or Parent or Guardian if Minor)*

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Patient Name
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Patient Signature *(or Parent or Guardian if Minor)*

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Date

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Patient Name
1)________________ 2)________________
Primary Insurance Secondary -if applicable

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Patient Signature *(or Parent or Guardian if Minor)*

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Date