Family Eyecare
Financial & Billing Policy

Thank you for choosing Family Eyecare to serve you and your family's eye health needs. We are pleased to participate in your family's health care and look forward to establishing a lasting relationship. We are committed to providing you with the best care available. The following financial policy is provided to avoid any misunderstanding and provide you with an outline of our expectations. **Your insurance policy is a contract between you and your insurance company. Please note it is your responsibility to become familiar with your plan. You are expected to know if routine procedures are covered and the time-frame in which they are allowed. If you do not understand your specific plan coverage, please call your insurance company or your HR department at work. The number for your plan is listed on your insurance card. We can often help with providing information to assist in filing claims, but you are primarily responsible for any charges that you have incurred as a patient with Family Eyecare.** Please review and sign the following financial policy prior to your office visit.

1. CO-PAYMENTS, DEDUCTIBLES, AND FEES – **All co-payments, insurance deductibles, and fees for service not covered by your insurance policy are due at the time service is rendered.** We make every effort to collecte balances up front. However, many fees will not present themselves until a final claim determination has been made by your insurance company. In those cases we will mail a statement to you for any outstanding balance. We accept cash, check, or credit cards (VISA, Mastercard, and Discover, Care Credit)
2. INSURANCE – Patients must complete and sign information and insurance forms prior to seeing the physician. **You must present a current insurance card at each visit. If you or your children do not present a current insurance card, you will be responsible for payment at the time of your visit.** You will receive reimbursement from Family Eyecare 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," in which case you are responsible for payment in full. 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 because of information that you have not provided 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 by Family Eyecare.
3. MINORS AND DEPENDENTS – The adult who brings a minor child into our practice accepts <u>final</u> responsibility for payment. We will send statements to the guarantor listed on your registration sheet, but time of service payment and final payment is the responsibility of the accompanying adult. Parents are responsible between themselves to communicate with each regarding treatment and payment issues. You will be able to receive a summary of each visit via the patient portal which may be used for parent communication.
4. PROMPT PAYMENT-**Just as we make every effort to accommodate you when you are in need of medical care, we expect that you will make every effort to pay your balance promptly.** If you have a financial hardship or if you are unable to pay your balance in its entirety please contact Family Eyecare to discuss payment options. We must have a signed payment plan and you must be paying regularly (each month) to keep your account from further action. **If your account becomes delinquent and you have not established or met payment options with Family Eyecare, your account will be turned over to a collection agency and we will ask you to seek your medical care from another office.**

By signing below, the responsible party acknowledges that he or she has read and understood the financial policy of Family Eyecare and is bound by its terms and conditions. You also understand that failing to sign this agreement may result in discharge from this practice.

Patient Signature:_____ Date:_____