ARMSTRONG · COLT
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OPHTHALMOLOGY

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FINANCIAL POLICY January 1, 2014

Patient Name_____ DOB: _____ PATIENT # _____

We thank you for choosing our practice for your eye care. In an attempt to avoid problems or misunderstandings with your bill please read our **Financial Policy**. We hope you understand that in order for us to continue to provide outstanding service to all of our patients, it is important that we receive payment for our services.

We participate with many medical plans as well as some vision plans. Please understand that insurance is a contract between ***you and your insurer.*** As a subscriber it is **YOUR** responsibility to know your **coverage and its limitations**. With the recent changes in health insurance coverage there are many individuals who have a **significant personal responsibility** in the form of deductible, coinsurance as well as copays. If known, we will collect any unmet deductible, coinsurance, and/or copay at the time of service. All patient responsibility for which you are billed is due upon receipt of that bill.

If we participate with your insurance, all services will be submitted for you. We do not submit claims for services which are non-covered. Routine exams and refractions are NOT covered by Medicare and many other plans. Charges for uncovered services will be collected at time of service. If insurance does pay for a service for which you have paid us, you will be refunded.

If your insurance requires a referral, it is your responsibility to obtain the referral prior to your appointment. If no referral is available at the time of your appointment, we will need to reschedule until the referral is obtained.

If your insurance has a specialist copay, we will collect it at check-in. Without the copay we will reschedule your appointment if it is not an emergency.

If you have an unmet deductible or coinsurance, we will collect it at the time of service or after the claim is processed and determined to be your responsibility.

It is your responsibility to ensure that the doctor you are seeing is participating with your insurance and that the visit or procedure is a benefit of that plan.

Outstanding Balances

We accept cash, personal checks with proper identification, Visa or Mastercard. All patient responsibility is due at the time of service. **Any/all outstanding balances are due upon receipt of your first statement and must be paid in full prior to receiving additional services or materials.**

If you are seen but unprepared to pay at the time of service, we may add a billing charge of **$25.00** to your visit. There may be a **$40.00** fee for checks returned by your bank. You may receive a delinquent letter if your balance is unpaid after 60 days. Unpaid balances over 90 days may be outsourced to a collection agency.

I have read this Financial Policy, and agree to the terms set forth herein.

Print Name _____ Signature _____ Date _____