Financial Policy

Thank you for choosing **Frankfort Eye Center as** your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. Our staff will work very hard to make sure your paperwork is filed accurately and promptly. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment.

All patients must complete our Information and Insurance form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE.

We accept all major credit cards, debit cards, checks & check cards, and cash.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbi-trary determination of usual and customary rates.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full pay-ment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/ MasterCard, or payment by cash or check at time of service has been verified.

Divorce Decrees

This office is NOT a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility of minor children rests with the accompanying adult.

Missed appointments

Unless canceled, at least 24 hours in advance, you will be charged a $25 fee for missed appointments. Please help us serve you better by keeping scheduled appointments.

Non Payment

In the event your account becomes delinquent, you will be responsible not only for the charges incurred but also any costs involved in collection on your account. These include but are not limited to interest charges, rebilling fees, court costs, attorney fees, and collection costs to collection agency of not less than 20%. Such contingency fee to be added and collected by the collection agency immediately upon your default and our referral of your account to said agency.

I have read the Financial Policy. I understand and agree to this Financial Policy:

Patient Name (Please Print): _____Date:_____

Insurance for Refractive Eye Care

We do not bill insurance for refractive exams, glasses, contact lenses, or refractive surgeries unless we are under contract with your vision care insurance plan. Since glasses and contact lenses are **special order** items we must collect at least 50% of the cost before we can place the order and the remaining balance must be paid when they are picked up. Refractive exams and contact lens fitting fees must be paid at the time of service. You will be given all necessary information to send to your insurance company so they can reimburse you directly. If during your refractive exam, a medical condition is diagnosed which requires a medical eye exam or surgery, we will bill your medical insurance for these services.

Insurance for Medical and Surgical Eye Care

As a courtesy to you and for your convenience we will bill your medical insurance company upon your request. We do require payment for all services that are not covered by your insurance plus any co-payment due. If we do not have an established history of what services your insurance will pay for, we may require payment in full at the time of service and your insurance company can reimburse you for these expenses. **The balance is your responsibility whether your insurance company pays or not.** We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event that we do accept assignment of benefits we may require that you be pre-approved on our extended payment plan or provide a credit card with authorization to bill that account for the balance. If your insurance company has not paid your account in full within 90 days, the balance will be automatically transferred to your credit card or the extended payment plan. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

Medicare

As a Participating Provider, we will bill your Medicare carrier. You are responsible for your (20%) co-payment and we must collect it each and every visit. You will be asked to sign a waiver showing you are aware of the services Medicare does not cover.

Failure to Obtain Referrals

Physicians at the Frankfort Eye Center are Eye-Care Specialists. Some insurance carriers require some of its members to obtain a referral from their primary care doctor prior to seeing a specialist. It is you responsibility to obtain a referral if it is required by your insurance company.

Secondary Insurers

Having more than one insurer DOES NOT necessarily mean that your services are covered 100%. Secondary insurers will pay as a function of what your primary carrier pays. We may bill your secondary carrier as a courtesy. You are responsible for any balances after your insurance(s) has cleared.

Failure to Provide Correct Insurance Cards

It is your responsibility to provide us with the correct insurance cards including both primary and secondary insurance cards. If your insurance company denies payment because you failed to provide us with correct insurance information, a fee of $25 will be added to your account. This will be your responsibility in addition to the balance.

Insurance Collection

Please understand that insurance reimbursement can be a long and difficult process for our office. In fact, insurers will routinely stall, deny and reduce reimbursements. To that end, our billing staff has undergone extensive and rigorous training to maximize your insurance reimbursement while reducing the time by which they pay.

I hereby authorize and direct my insurance carrier to pay directly to Frankfort Eye Center any amounts due under my insurance plan. I consent to the use/disclosure of my protected health information by Frankfort Eye Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or conducting the health care operations of Frankfort Eye Center.