



## Patient Financial Policy

Thank you for allowing us to participate in your eye care. If you have insurance, we are committed to helping you receive your maximum allowable benefits. We understand that the insurance field can be quite confusing. Our financial policy is provided to assist you in understanding your responsibility to both Eye Consultants and your insurance carrier. Ultimately, however, any and all financial liability rests with the patient.

**Supplemental insurance:** If you have supplemental insurance, we will send a claim to them as a courtesy.

**Refraction service & fee:** Refraction is the process of determining your best-corrected vision. It is an essential part of an eye examination and is necessary to write a prescription for glasses or contact lenses. Our fee for the refraction is \$40.00 and will be collected at the time of service. Refraction is not a covered benefit by most insurance companies, including Medicare.

**Insurance:** Your insurance policy is a contract between you and the insurance company. As medical providers, our relationship is with you and not your insurance company. While the filing of insurance claim forms is a courtesy we extend to our patients, any unpaid charges are your responsibility. You are expected to know and follow all regulations as agreed to by you and your insurance company regarding referrals, second opinions or pre-certifications. **Any out of pocket expenses such as co-pays, coinsurance and deductible must be paid at the time of service.** Failure to provide copies of insurance cards may result in denial of your claim, and you will be held responsible for the balance. **If you have a managed care plan (HMO) that requires a referral to see a specialist, you must obtain a referral in order for your visit to be covered. If you do not have a valid referral, you will be asked to pay for the visit prior to your examination.**

**Services rendered to minor/dependent patients:** We will look to the adult accompanying the patient for payment on the date of service. In cases of separation or divorce, when presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply the subscriber's name/address/phone/date of birth and social security number. We request that you inform the subscriber that their insurance has been used

**Co-pays:** In accordance with your insurance contract, your copay is due at the time of service. If you do not bring your copay with you to the appointment, we will gladly reschedule your appointment.

**No Insurance:** Payment in full is due at the time of service

**Methods of payment:** We accept cash, check, Visa, MasterCard and Discover

**NSF Checks:** Any check that does not clear your bank account will result in a \$30.00 fee

**Refunds:** If an overpayment has been made, a refund check will be issued to you. Overpayments for \$5.00 or less will be credited to your account

**Statements:** If there is a balance on your account after filing your insurance carrier, you will receive a statement. Payment is expected **within 30 days** from receiving your statement. If you have any questions regarding your statement, please contact the Billing department immediately. Due to the high cost for processing statements, we will no longer send out multiple statements. Your account will be considered delinquent after 30 days from your first statement. If your account is turned over to our collection agency, you agree to pay any fees imposed by the collection agency.

I have read and understand the financial policy of Eye Consultants of Kentucky regarding payments and insurance. I agree to pay for services and tests not covered by my insurance plan. I also understand that I am responsible for following my insurance plan's regulation, policies and procedures.

---

Patient signature/Guarantors Signature

---

Date