EYESIGHT ASSOCIATES FINANCIAL POLICY

1. **Proof of Insurance**: Providing quality medical care is our primary goal. We participate with most insurance programs, including Medicare, some Medicaid plans and Tricare as a service to you. You, the patient, have the ultimate financial responsibility for services rendered. If you do not provide proof of valid insurance at the time of service, you will be responsible for all fees upon checkout.
2. **Coverage and Benefits**: Most medical insurance companies do not cover annual vision exams. Some insurance plans offer routine coverage, but ***WE DO NOT PARTICIPATE WITH ANY VISION PLANS.*** If you have questions regarding your coverage benefits, please direct them to your employer or your insurer's representative. It is your responsibility to inform us of any secondary benefits of special requirements, such as Worker's Compensation, or you will be financially responsible for services rendered.
3. **Refraction Policy**: A refraction is performed to determine whether a glasses prescription is needed or an existing prescription needs to be changed. It is also frequently **needed** information for the doctor to monitor the progression of a disease process like cataracts or macular degeneration. There is a separate fee for this test. It is not included in the exam. Most insurance, including Medicare and Medicare Advantage plans, ***DO NOT COVER THIS FEE***. It will be due at the time of service.
4. **Payment is due when services are rendered**: You are responsible for all co-pays and deductibles required by ***your*** insurance contract. Co-pays or co-insurance need to be paid the day services are rendered. Any non-covered services or treatments that you request or your physician recommends are also your responsibility. As per HCFA guidelines, if you have Medicare or Tricare, and you have a procedure that is sometimes covered and sometimes not, you will be asked to sign an **A**dvanced **B**eneficiary **N**otice form to acknowledge that you understand that you will be responsible for the charges if your insurance does not cover. **ABN**s only apply if a service is sometimes covered and sometimes not. If a service is never covered, you will be asked to pay at the time of service. If you do not have insurance, all fees are due at the time of service.
5. **Our Responsibility to Report Non Compliance**: Many insurance contract request that we report patients who repeatedly refuse to pay co-pays, deductibles, and non covered services or repeatedly "no show" for appointments. Such habits could result in you losing your insurance coverage.
6. **Billing, Payments, and Over Payments**: If an overpayment is made by you, a refund will only be issued if there are no other outstanding debts on you or your family's account. Please inform us of changes in address, phone or employer.
7. **Past Due of Delinquent Accounts**: Failure to meet your financial obligations may result in collection proceedings, which negatively affect your credit score. We reserve the right to add finance charges up to 30% of your balance. If we file your insurance and they have not paid in 45 days, the balance may be transferred to your responsibility.
8. **Returned Check Policy**: All returned checks will be sent to Check Care of Macon, GA and you will be subject to all related fees. You may also be billed a $35.00 returned check fee or any fees that we incur as a result of your check being returned to our bank.
9. **Retail Goods Policy**. Optical and low vision aid orders will not be placed without a deposit. Cancelled or returned items are subject to a $30 non-refundable restocking fee.
10. **Missed Appointment Fee**: Any missed appointments not cancelled or rescheduled 24 hours prior to the appointment time are subject to a $50 fee.

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Patient signature Date