FINANCIAL POLICY

We are dedicated to providing our patients with the best possible care and service, while keeping the cost to you from rising at unreasonable rates.

We ask for your help by understanding and cooperating with our Financial Policy.

It is important for you to understand that health insurance coverage is an agreement between you and your insurance company AND your doctor's bill for services provided is an agreement between you and your doctor.

YOUR Responsibility: Our physician(s) participate with several insurance companies. It is your responsibility to call your insurance company to verify that the doctor you are seeing is participating. It is your responsibility to keep us informed of any changes in your insurance coverage, address, telephone, and employer information. Insurance claims denied because you did not provide current and correct information will be due and payable by you.

If we do not participate with your insurance company, we will bill your insurance carrier as a courtesy to you; however, we will expect payment from you. If you do not have valid insurance information, or we cannot confirm coverage, we will consider you "self-pay" and ask for full payment.

All co-payments, co-insurances, deductibles and payments for non-covered services are the patient's responsibility and will be collected by our staff at the time of service.

Referrals: If your insurance company requires a referral/authorization from the Primary Care Physician, be sure that you have obtained a valid referral/authorization prior to your appointment. If you do not have a valid referral/authorization, you may be asked to reschedule. You agree to be responsible for payment of your account regardless of referral status.

You understand that it is your responsibility to know and abide by the terms of your benefit coverage including but not limited to properly securing referrals for specialized care before making appointments. You also understand that you are responsible for full payment of services provided if you fail to supply all required referral forms.

Below is a detailed explanation of different insurance plans.

Medicare and Medicare Advantage Plans

As a participating provider, we will bill your Medicare carrier. **If you have a Medicare Advantage plan, you must present us with the appropriate insurance card along with your traditional Medicare card.** You are responsible for your annual deductible and 20% co-insurance and we must collect it. We will be happy to bill your secondary payer as well. If a balance remains after we bill Medicare and your secondary insurance carrier we will bill you for the balance, which is payable by you upon receipt of our statement.

Medicare Patients Residing in a Rehab or Skilled Nursing Facility

Patients temporarily or permanently residing in a rehab or skilled nursing facility often have restrictions on services approved for payment in physician offices. It is critical that you let our office staff know this information and have the facility information available

even if the reason for the stay is unrelated to your eye condition. Prior authorization needs to be obtained for any services provided to you in our office while you are staying in one of these facilities. Lack of prior notification could result in the patient being responsible for the balance.

HMO PLANS

All co-pays must be paid at each and every visit. There can be no exceptions due to contracting and uniform compliance rules. **You are responsible for getting proper referral information and authorizations in advance of your appointment. It is the patient's responsibility to verify with your insurance company that our physician is enrolled in your insurance plan.** You will be responsible for payment for services denied by your HMO for lack of referral and/or pre-authorization.

PPO PLANS

We have agreed to accept the discounted rate from your plan, however all co-insurance and deductibles are your responsibility and **due at the time of each and every visit**.

Financial Assistance for Injectable Medications

Due to the high cost of some ophthalmic injectable medications, we ask that you investigate your insurance to better understand your benefits and also investigate insurance coverage when you have the option to switch plans. We also ask that you follow through with these available Patient Assistance Programs to minimize your potential cost for these expensive medications. We will do our best to assist you with any part of this process and are committed to helping you determine your eligibility for these programs**.** Physician office staff can facilitate getting you the appropriate forms to complete for these assistance programs and it is your responsibility to follow up to ensure timely submission. **Ultimately, you are responsible for any costs not covered by your insurance or drug assistance programs.**

ACUITY OF NEED

ALL INSURANCE PLANS, including but not limited to Medicare Replacement Plans, Managed Care and Commercial Carrier Plans: Should the insurance benefit verification determine you only have Urgent and Emergent Care Coverage, and your services are not urgent/emergent you will be responsible for paying the fee for all services at the time of service.

PAYMENT FOR SERVICES PERFORMED

1. Our office accepts Visa, MasterCard, Discover, and American Express, as well as Cash, Debit Cards and Personal Checks for payment of service. A small service charge may be applicable to all credit card and debit card transactions, and you will be advised of such charge at the time of payment should you use one of these methods.

2. Any co-payments required by an insurance company must be paid at the time of service. This is an insurance requirement.

3. All payments re expected at the time of service. Should your account require action of a collection agency, you would be financially responsible for all collection and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance.

4. A $20 charge may be added to all amount due over 30 days. **Unpaid Balance Fees**

No Insurance or Services not Covered by your Insurance

Patients without any health insurance or patients who have coverage but the services are not covered by your insurance are expected to pay **in full prior to or at the time-of-service**. This includes all office visits, tests, injections and surgical procedures.

RETURNED CHECK FEE

There is a $30 banking fee for all returned checks. If your check is returned from the bank, we will not accept a check as payment on your account. Future payments must be made with cash, money order or credit card.

CHARGES TO ACCOUNT: We shall retain the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

MISSED APPOINTMENT FEE: Patients who do not show up for an appointment, or fail to reschedule or cancel with the less than 24 hours' notice will be charged a $50.00 fee. This charge will not be reimbursed by your insurance. Patients with three missed appointments may be asked to transfer their records to another doctor.

MISSED TEST FEE: Patients who do not show up on time for a scheduled office based test, or fail to reschedule or cancel with less than 24 hours' notice will be charge a $150.00 fee. This charge will not be reimbursed by your insurance.

MISSED PROCEDURE FEE: Patients who do not show up on time for a scheduled procedure, or fail to reschedule or cancel with less than 48 hours' notice will be charge a $500.00 fee. This charge will not be reimbursed by your insurance.

RELEASE OF RECORDS: If you require or request a copy of your records for personal use, you must submit a request and pay a copying/printing fee of $1.00 per page, up to State maximum then in effect.

Copies of records, including payment history, will be provided at no charge to other healthcare providers pursuant to a valid HIPPA authorization.

FORM COMPLETION: Additional fee is charged for form completion, including Disability, DMV/FMLA/Government Forms forms, etc. Fees vary depending on the complexity of the forms.

OVERPAYMENT: Any overpayment that I make to Annan Retina Eye Center will be applied as a credit to my account. If I prefer a refund, I will need to contact the billing department for that request and to confirm my mailing address to issue the refund.

RIGHT TO AMMEND: You understand and agree that Annan Retina Eye Center may amend the terms of this Financial Policy at any time without prior notification to the patient.

I have read and understand this financial policy and agree to its terms. I agree to pay for services rendered. I agree to pay attorney fees and collection costs in the event it becomes necessary to retain such services for collection of my account.

I authorize the release of medical information and records concerning my treatment to Medicare, Medicaid and/or other insurance companies and assign my claim for medical benefits to the extent permitted under applicable law or insurance agreements. I release all legal responsibility or liability that may arise from the above authorizations and agreements:

PATIENT SIGNATURE:_____ **DATE:** _____

OR RESPONSIBLE PARTY:_____

Printed Name of Patient _____