Eye Guys Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best quality care possible and will work with you to meet any special needs you may have. The following information is an agreement between Eye Guys and you, the Patient or Responsible Party. By signing this agreement you acknowledge receipt of our financial policy and agree to pay for all services received.

Payment Due at Time of Service: In order to provide you with high quality care at a reasonable cost, we must require payment of any co-pay, deductible, and non-covered service at the time services are rendered. If you are unable to pay at the time of service we will gladly reschedule your appointment. We accept Cash, Check, Credit Card, and Care Credit.

Insurance Participation: Our office participates with a variety of insurance plans and networks, and we will gladly submit claims to those carriers with which we participate and act as your advocate in an effort to get your claim paid. However, you are ultimately responsible for all charges. It is your responsibility to provide us with all current health insurance information. The following outlines our insurance participation policies:

- ☐ Your insurance policy is a contract between you and your insurance company. While we will assist as much as possible, it is your responsibility to be familiar with your coverage and contact them directly if you have questions.
- ☐ You must bring your insurance card with you to every visit and make us aware of any changes in coverage in a timely manner.
- ☐ Failure to provide our office with the correct insurance information may result in claims being denied and balances being transferred to patient responsibility. It is imperative that you provide complete, accurate and current information in a timely manner.
- ☐ You are expected to pay your co-pay, deductible and/or coinsurance at each visit. In order to comply with the participation agreement we have with your insurance company, we must collect any co-pay and/or deductible amount at the time of service.
- ☐ It is your responsibility to know if we participate with your insurance plan or not prior to services being rendered. If we do not participate with your insurance plan you will likely have a higher out-of-pocket expense.
- ☐ If you have a high deductible plan we reserve the right to collect payment in full at the time of service.
- ☐ If you are seen after-hours or on weekends you may be assessed an after-hours charge. We will file this charge to your insurance, however, the claim is likely to be denied as a non-covered service making the balance your responsibility.
- ☐ In order to protect your identity and file your insurance claim, we will keep your photo ID scanned into your chart **OR** we will require you to present a photo ID at each visit so we can confirm your identity.

Uninsured Patients: If you do not have insurance, payment is required in full at the time of check in.

Past Due Accounts and Returned Checks: If your balance is not paid in a timely manner, we reserve the right to forward your account to an outside collection agency. If your account is forwarded to an outside collection agency, your relationship with this practice will be terminated. All fees assessed by the collection agency will be charged to you and become part of your outstanding balance. Returned checks are subject to a $25 processing fee. The amount of the returned check plus the processing fee must be paid by cash, money order or credit card within 10 days of receipt of written notification from our office. We require you to provide your social security number, which will be kept private and confidential, and used for collection purposes only. If you refuse to provide your social security number then payment is required in full at the time of check in.

Missed/No Show Appointments: When you miss or “No Show” for an appointment you deny valuable time to another patient in need of medical care. We realize that unexpected circumstances may arise but we ask that you call at least 24 hours in advance to cancel or reschedule your appointment if possible. It is our policy to charge a No Show fee of $25 for missed or cancelled appointments without 24 hours notice. We will waive this fee for the first “No Show” appointment.

Minor Patients: If the patient is a minor (anyone younger than 18 in GA / 17 in SC), a parent or guardian MUST be present at the appointment. If a parent or guardian cannot be present we will gladly reschedule the appointment.

Refractions: The refraction is the diagnostic portion of the eye exam which determines whether your vision can be improved with glasses or contact lenses. It is a non-covered service by Medicare and is rarely covered by Private insurance. These plans consider a refraction to be a vision service and not a medical service. Therefore, you are responsible for payment of the refraction at the time of service. We will bill your insurance plan for this diagnostic test and refund you in the event your insurance plan pays the claim.

Surgical Appointments and Fees: There are several steps involved in preparing for your surgery so it is important that you keep your scheduled surgery appointment in order to complete your treatment as planned. It is important that we are able to contact you about any questions or changes regarding your planned surgery. It is your responsibility to contact our office as soon as possible if there is a change in your contact information. If we are unable to contact you in a timely manner your surgery may be cancelled. It is also your responsibility to advise us if there is a change in your insurance. We will verify insurance benefits prior to the date of your surgery. Payment in full is required prior to elective procedures. A cash discount is offered to patients who are not insured.

Aiken Location:

Routine Vision Coverage: We accept some routine vision plans at our Aiken location only. Ask our front desk associate if we accept your plan. The vision plans that we accept in our Aiken location provide you with a baseline eye evaluation to update your glasses or contact lens prescription only. If the doctor discovers a medical eye problem during a routine vision exam, we will inform you that your visit is now a medical exam and will be billed to your medical insurance. Alternatively, you may choose to finish the routine vision examination and return at a later date for the medical exam if the doctor deems it medically safe to do so.

Eyeglass Orders: If you have insurance coverage to help pay for your eyeglass order, we will collect payment for any non-covered options and/or any overages for which your insurance will not pay before your order is placed. If you do not have insurance coverage to help pay for your order, we will collect the balance in full before placing the order. If you are dissatisfied with your new eyewear purchase for any reason, you may return them within 30 days of delivery and we will gladly exchange them for equal value or refund the frame in full. Please note: Your eyeglass prescription and your lens measurements are unique to you. This means that your lens order must be treated as a Special Order because once the order is placed we cannot cancel it or return your lens(es). Accordingly, all canceled or returned lens orders are subject to a cancellation fee of 50% of the lens charge.

Contact Lenses: Contact lens services (original fitting and annual evaluations) are in addition to eye exams. Because contact lens wear is almost always elective, we require that you pay for any contact lenses in full before the order will be placed. If you have insurance coverage to help pay for your contact lens order, we will collect payment for any overages for which your insurance will not pay before your order is placed. If you need to return your unopened, non-damaged contact lenses for any reason, we will gladly exchange them for equal value.

Thank you again for choosing our office. If you have any questions concerning the above financial policy, please ask to speak to one of our benefits counselors.

I HAVE READ, UNDERSTAND AND AGREE TO COMPLY WITH THESE POLICIES.

Name: _____ Date: _____

Print Name of Patient

Signature: _____ _____

Signature of Patient or Responsible Party Relationship to patient