Community Eye Care of Indiana

PATIENT FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Please understand that payment for services is a part of that relationship. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment.

PATIENT INFORMATION: A fully completed, current patient registration will be on file in the patient chart during the time in which the patient is considered an active patient. Patient registration will be updated by the patient yearly and will include where the patient can be reached by phone. A signature by the responsible party is required.

INSURANCE CLAIMS:

Primary Insurance: We will file claims with the patient's insurance upon the patient's submission of proof of insurance (i.e., insurance card indicating coverage, identification number and group number). In the event the patient has insurance coverage but cannot provide documentation, payment is due at the time of service. Upon receipt of the insurance card, we will submit the health insurance claim form indicating patient payment at time of service.

Secondary Insurance: Claims will be filed with secondary insurance if adequate information is received at the time of service. However, if payment is not received in our office within 45 days after filing, the responsibility will be transferred to the patient and due upon receipt.

PATIENT FINANCIAL RESPONSIBILITY: If no insurance is to be filed by us, or if we are not a participating provider in your insurance plan, **full payment is expected**. If necessary, we can set up a payment schedule. Payment arrangements will be made with a signed Payment Agreement and the approval of the Office Manager.

Co-payments, deductibles, co-insurance and payment for non-covered services are due at the time of service. We accept cash, checks and credit cards.

REFERRALS: It is the patient's responsibility when they make an appointment with our office to contact their insurance company or primary care physician to get a referral. If you arrive at your appointment and do not have a referral, we cannot guarantee that your insurance company will pay for the visits with our office.

MINORS/DEPENDENTS: Children under the age of 18 will require the signature of a responsible party on the registration form.

WORKERS' COMPENSATION: Workers' compensation will be filed if the patient notifies us when scheduling the appointment and supplies billing information at check-in. Details of the accident will be required and a workers' compensation form must be completed.

METHOD OF PAYMENT: Acceptable methods of payment are cash, check, VISA and MasterCard. VISA and MasterCard payments can also be accepted by phone or fax.

RETURNED CHECKS: Checks returned by the bank will be charged back to your account. An additional fee will be charged to your account, per office protocol. The fee charged should be no less than the amount charged by the bank for each submission.

PAST DUE ACCOUNTS: Any outstanding balance, after insurance has paid, will be invoiced to you on a statement. Payment is due upon receipt of the statement.

Prolonged delinquency in payment may result in preparation of account for small claims court, collection agency and/or credit bureau reporting with possible discharge from the practice. In the event an account is turned over for collection, the person financially responsible for the account will be responsible for all collection costs including reasonable attorney fees and court costs.

A patient may remit in-full all outstanding charges owed on account, including amounts previously placed with the collection service. Under these circumstances, a physician may reserve the right to re-establish the patient to active status in the practice.

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MISSED APPOINTMENTS: We request the courtesy of a 24-hour notice of cancellation. **You will be charged a $50 no show charge for procedures.** No show charges for missed procedures are billed directly to the patient and are not filed to insurance carrier.

ACCOUNT CONSULTATION: Physicians do not discuss financial issues. Our billing staff is trained to discuss your account and make payment arrangements. They will be happy to help you, but if you need further assistance please ask to speak with the Office Manager.

MOTOR VEHICLE ACCIDENT/THIRD PARTY LIABILITY: If you are being seen as a result of an automobile accident or an accident that involves coverage other than medical insurance, you will be considered a self-pay patient, with third party liability reimbursement. Our office will provide you with a receipt and itemized bill which you can use to seek reimbursement. We will comply with all government payor policies. Responsibility for payment remains solely with the patient or guarantor for all motor vehicle accidents or an accident that involves coverage other than medical insurance. Payment in full or payment arrangements must be made at the first visit.

MEDICAL RECORDS: If you need to transfer your records to another physician, please contact the office. They will provide you with the HIPAA compliant documents. Indiana Medical Code for Record Co-paying Charges. 760 IAC 1-71-3.

NOTE TO DIVORCED PARENTS OF MINORS: Our office cannot be involved in divorce arrangements. Therefore, it is the policy of this office to hold the parent who brings the minor child in for services responsible for payment.

Optical Shop

In addition to the above noted in the Patient Financial Policy, the following is applicable to optical merchandise sales:

Return Policy: A return must be made within 30-days of delivery date. Frame must be in perfect resale condition. We will refund 100% patient cost of your frame. As your prescription was a custom order, we will refund 50% of the patient cost for the lenses

Frame Warranty: All frames purchased come with a one-year defect/breakage caused by reasonable use warranty, unless otherwise noted by manufacturer. All breakages must be normal wear and tear. We will either repair or replace your frame with the same frame at no charge (all parts of broken frame must be presented at time of return). If a frame has been discontinued during the warranty period we will replace it with an equivalent value frame at no charge (does not include lenses). We are unable to extend this warranty to frames purchased elsewhere.

Lenses Warranty: All lenses purchased from our optical shop have a one-year defect warranty *under normal wear and tear,* unless otherwise noted by manufacturer. If you are having a problem with your new prescription, please come into the optical center within 30-days of delivery of your merchandise. If we are unable to find a solution, an appointment will be made with the doctor for a re-evaluation. We will replace the lenses at no charge. Breaking and chipping of lenses are not included.

Progressive Lenses: We understand that some patients require time to adapt to progressive lenses. If you are having difficulty with the lenses, we ask that you speak with our optician. Adjustments may be necessary. If within 30-days you are not comfortable wearing your lenses, we will be happy to replace them at no charge to either a lined bifocal, lined trifocal or single vision lenses.

Re-Using Existing Frames: Because a frame may crack or break when inserting new lenses, we cannot be responsible for any damage to your frame if you choose to use your existing frame. Regardless of condition or age of the frame, this disclosure applies to any existing frames being re-used at your request.

Restyling Fee: In the circumstance when a patient request an additional optical fitting appointment because they are unhappy with the style that they have chosen and desire to choose a different style, a $25.00 restyling fee will be

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charged to the patient's account. Restyling is applicable for up to 30-days from the date of delivery of your merchandise. Refund policy is applicable. Restyling fees are not filed with insurance.

Restocking Fee: In the circumstance a patient cancels a merchandise order, a restocking fee will be charged to the patients account. The restocking fee is charged at fifty percent (50%) of the patient cost of the merchandise. Restocking fees are not filed with insurance. Any remaining prepaid credit balance will be refunded back to the patient.

Medicare: Medicare may help cover the cost of one pair of eyeglasses, per cataract surgery. These glasses may be bifocals, trifocals, reading glasses, or sunglasses. You may choose additional features above what Medicare allows and those features will be a direct out of pocket expense to you. As a courtesy to our surgical patients, our office will file the claim with Medicare for your new eyeglasses and invoice you for any additional features you may have ordered.

Payment: Full payment is due at the time of order. We accept cash, checks, VISA, MasterCard.

ACKNOWLEDGMENT OF RECEIPT: I have read, understand and agree to the financial policy.

_____ _____/_____/_____

Patient/Guarantor Signature Date

MEDICARE/MEDIGAP AUTHORIZATION: I request that payment of authorized Medigap and/or Medicare benefits be made either to me or on my behalf to Community Eye Care of Indiana for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to _____ _____(*name of Medigap insurer*) and/or the Center for Medicare and Medicaid Services any information needed to determine these benefits or the benefits payable for related services.

_____ _____/_____/_____

Patient/Medicare Beneficiary Signature Date

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY PRACTICES:
This is to acknowledge my receipt of this facility's Notice of Privacy Practices.

_____ _____/_____/_____

Patient/Guarantor Signature Date