Poplarville EYE CLINIC

INSURANCE/PAYMENT INFORMATION: With the ever changing healthcare industry, we want to make sure every patient is aware of our insurance and billing policies. The more you know, the better we can service your eye care needs.

Payment is due at the time of your exam.
Due to the increasing costs of providing medical care, we require patients to pay their co-pay, deductible, and all out of pocket expenses before they leave the office.

Patients on HMO Policies:
Our staff will strive to make sure that all patients on an HMO plan have a referral for their visit, however it is the patient's responsibility to insure the office has this before services are rendered. Patients on an HMO policy are required to present a referral from the Primary Care Physician on every visit to our office. We cannot bill your insurance without the referral.

Non Covered Services:
If we suspect that your insurance company may not cover a service, we will ask that you sign a form in advance acknowledging that you have been advised the service may not be covered and that you will be financially responsible. This applies to services that we feel is needed in your treatment plan, but that your insurance company may deem non-covered. All other non-covered services will be billed to you in accordance with your specific insurance policy.

Refraction Policy:
It may be necessary for our office to perform a Refraction Test. While Medicare and some major insurance carriers do not cover this test, it is necessary to determine your visual acuity. This test can be used to determine your need for glasses, but it can also detect vision loss. Some of the time vision loss is slow and progressive and the patient may not even notice, that is why a physician will check the patient's vision by refracting them. This test can also uncover other problems a patient may be unaware of. This test is charged separate from the exam because Medicare has deemed that a refraction is not a "medical service". However, this is the ONLY way to detect some types of vision loss. The Office of Inspector General has deemed that not charging a patient for a service is an "inducement" to the patient, and therefore illegal, which is why we charge for this service to be done. A refraction may not be done at every visit. This varies based on the patient's diagnosis. **The fee for a refraction is $20, and due at the time of service in addition to any copays or deductibles.**

Billing to your insurance:
Our office will bill all covered services to a Primary and Secondary Insurance Policy. We do not bill to more than two insurance carriers. By giving us your insurance information you authorize our office to request payment be sent directly to us. We will also make reasonable appeals for payment when necessary. We will give insurance carriers a maximum of 60 days to pay the claim. Failure for them to pay in a timely manner will result in the balance being turned over to you. We encourage you, the patient, to be involved and make sure your insurance is paying in a timely manner.

Unpaid Claims:
After 120 days if the balance on your account has not been paid, and a payment arrangement has not been set up with our Billing Department, the balance will be forwarded to our collection agency. The patient is responsible for any collection charges, attorney fees, court cost and finance charges that accrue. Continued access to our practice will be terminated if billing policies are ignored. If financial obligations arise, please contact our Billing Department immediately. Monthly payment plans can be set up with payments as low as $100 a month.

The patient or responsible party agrees to the Physician's reasonable and customary fee for medical services. The receptionist will accept cash, check, or credit card for routine visits as you leave. If financial problems arise, please make special arrangements. By signing this form, you acknowledge financial responsibility and authorize Poplarville Eye Clinic to release any information acquired in the course of your exam or treatment to other physicians, etc for health reasons and consent to the use of photographs for the purpose of documentation, publications in medical journals or presentations during medical meetings.

Patient Signature:_____ **Date:**_____