Whitten Laser Eye
Financial Policy

Thank you for choosing **Whitten Laser Eye** as your healthcare provider. We are committed to providing you with quality and affordable healthcare. We realize that the cost of healthcare is a concern for our patients, and we are available to discuss our professional fees at any time. The following is a statement of our Financial Policy, which you must read, agree to and sign prior to treatment. Carefully review the information and please ask if you have any questions about our fees, policies or your responsibilities.

PATIENTS WITH INSURANCE: Valid health insurance information must be provided to ensure appropriate reimbursement for your care. We ask that you present your insurance card at every visit. Patients are responsible for any pertinent deductibles, copayments, "non-covered" services resulting from the insurance claim processing. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

CO-PAYMENTS AND DEDUCTIBLES: Co-payments are due at the time services are rendered. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients is a direct violation of our contract with the insurance provider. If you are unable to pay your copayment today, your appointment will be re-scheduled.

MEDICARE PATIENTS: We will file to Medicare on your behalf, and with valid and effective secondary/tertiary coverage will also forward claims directly. Patients will be responsible for any resulting coinsurance and deductibles not covered by your additional (secondary/tertiary) insurance. Patients are responsible for non-covered services/supplies under separate notice (referred to as an ABN).

REFERRALS: Valid referrals and authorizations, as required by your insurance (including worker's compensation carriers), must be received before services are rendered. Otherwise your appointment will need to be rescheduled.

WORKER'S COMPENSATION and MOTOR VEHICLE ACCIDENT: We will file a claim to W/C carriers and/or auto claims with valid information. You must obtain a claim number, phone number, contact person and name and address of the insurance carrier **PRIOR** to your visit. Payment for any services that we provide will ultimately be your responsibility if not paid promptly by another party.

SELF PAY: Self pay accounts are patients without insurance coverage. **You are responsible for paying 100% of the charges at the time services are rendered.**

COVERAGE CHANGES: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

STATEMENTS: A statement will be sent to you once it becomes patient responsibility. It is our practice to bill patients once a month. If you wish to dispute the validity of the balance, we ask that you contact us immediately. Failure to make a timely payment will result in further collection action.

COLLECTION OF OUTSTANDING BALANCES: All outstanding balances will be addressed at a patient's follow-up appointment. We do ask that any outstanding balances are taken care of at that time unless discussed with either the Billing Manager or the Collections Specialist.

FORMS COMPLETION: We do charge for completion of any forms that need to be completed by the physician. The fee will be discussed when the form is presented to the Front Desk.

CONTACT LENSES: By signing this document you are agreeing to be responsible for the overall cost of your lenses and any contact lens fitting fees. If using your insurance, please be aware that if your insurance denies any coverage for your contact lenses, you will be held responsible for the balance. Fitting Fees and Contact Lenses must be paid at time of service/pick-up. If there is insurance coverage available to the patient for a fitting fee, the patient will be reimbursed after the insurance claim has been completed.

REFRACTION FEE: A refraction is a necessary part of an ophthalmic examination to help determine your best possible vision and to aid the physician in determining if there is a medical reason causing your symptoms. Most major insurance companies *do not cover* charges for a refraction. The fee for refraction is $50.00. These amounts are to be paid in full at the completion of your visit if a refraction was done and is not a covered benefit of your insurance plan.

PAYMENT METHODS: We accept payment by cash, check, MasterCard, Visa, Discover, American Express and Alphaeon Credit.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

AUTHORIZATION/ASSIGNMENT OF BENEFITS: For services rendered to me, I hereby authorize the release of private health information for the purposes of treatment and re-imbursement for such care. In addition, I hereby authorize and assign benefits directly to **Chesapeake Eye Care Management.** I have read and understand the above described Practice financial policies and patient responsibilities pertinent to me (and/or guarantor).

Signature or Responsible Party: _____

Print Name of Responsible Party: _____

Date: _____