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Financial Policy

We are committed to providing you with the highest level of service and quality care. If we are providers for your medical insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, any and all financial liability rests with the patient.

Our office participates with most major insurance plans. We provide **Medical & Surgical ophthalmologic care to our patients, as opposed to routine eye exams. We do not participate with any vision plans (VSP/Davis, Vision, etc.). A refractive examination is not a covered service by most insurance companies including Medicare. If you receive a prescription for glasses, you will be charged $80.00 which is payable at the time of the visit.**

Initial _____

If you have a **Managed Care Insurance plan that requires a referral to see a specialist**, you must obtain a referral in order for your visit in our office to be covered under your medical insurance. If you do not have a valid referral and still want to be seen, you will be asked to pay for the visit prior to your examination.

Initial _____

It is the patient's/parent's/guardian's responsibility to:

1. Be familiar with the benefits of your plan, including co-pays, co-insurances and deductibles.
2. Bring all of your current insurance cards to all visits and notify us of any and all changes to your insurance coverage.
3. Provide our office with current information including address, phone numbers, and employer. A copy of your driver's license will be kept on file for your protection.
4. In accordance with your insurance contract, you must be prepared to pay your co-pay or co-insurance including deductibles, any non-covered service and any other balance that the contracted insurance companies, allow but do pay at each visit. If you do not make these payments at the time of your visit, you will be charged an additional $10.00 billing fee. We accept cash, checks, VISA, and MasterCard credit cards. Credit card numbers, when used, will be kept on file and we will charge your account for any balance due per insurance company.
5. Patient accounts that become delinquent shall be assigned to an outside collection agency for resolution. Such assignments gives the patients the responsibility for the current balance plus the additional costs incurred in the collection process including by not limited to, interest, agency fee, filing fee, attorney, and court costs.
6. Any payments made by check that does not clear your bank account will result in a $25.00 fee, which will be added to your account and must be paid before the next visit.
7. Patients are responsible for calling the office 24 hours prior to their appointment to cancel or change their appointment. If you do not call 24 hours prior you may be billed an office visit charge of $50.00 for not showing or calling in.

Initial _____

For all services rendered to minor/dependent patients, we will look to the adult accompanying the patient to be responsible to provide all personal and insurance information, give consent for treatment, authorize payment for services, and make payment at the time of service for all professional fees incurred during evaluation and treatment. It is the responsibility of that adult to obtain a referral when applicable before seeing the physician. This office shall not be responsible for the enforcement of any custodial arrangements regarding the child's treatment, insurance coverage, payment due, and all other matters pertaining to medical services. No information shall be released to a non-custodial parent without the written consent of the custodial parent.

Initial _____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO CCES FROM MEDICARE, PRIVATE, AND GROUP INSURANCE COMPANIES, THE RELEASE OF INFORMATION FOR ELECTRONIC BILLING AND THE RELEASE OF MEDICAL INFORMATION.

1. Payment: I hereby instruct and direct Medicare and/or my insurance company to pay by check or direct deposit, according to my medical insurance benefit allowable, otherwise payable to me to: Cataract and Cornea Eye Specialists, LLC for professional charges incurred by myself. The payment will go directly to the appropriate date and total charges for the professional services rendered. This is a direct assignment for my rights and benefits under this policy.
2. I authorize CCES to submit my medical claim electronically.
3. I authorize CCES to disclose all or any part of my medical record to a third party, including, but not limited to, any person or corporation, or their designee, which may be liable under a contract for payment of all or part of CCES' charges, such as insurance companies, worker's compensation payers, Medicare and hospitals or medical employers, quality assurance and peer review committees, utilization review organization, accrediting surveyors, clinic and treating physicians, other healthcare providers that the doctor's may refer to in order to provide continued care and professional liability insurance carriers.
4. Medical Research and Education: Medical information including photographs and videography may be released for use in medical studies, medical research, and medical conferences. **YES or NO**

Initial _____

I understand that the authorization granted above may be revoked by me at any time. The authorization will stay in effect as long as the need for the above information exists. A photocopy of this assignment shall be considered as effective and valid as the original.

I have read and understand the above financial policy.

_____ _____

Signature of Patient/Guardian/Parent Date

_____

Print Name of Patient

_____ _____

CCES Witness Date

EYE SPECIALISTS
CATARACT & CORNEA

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