



## Financial Policy

Effective 10/1/2005; Rev 9-2008

We at Total Eye Care Centers, PC are pleased you have chosen us to take care of your eye care needs. We firmly believe that a good physician/patient relationship is based upon understanding and communication. Thank you!

### **Your Visit to Our Offices**

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Prior to your visit to our offices, you will receive a Pre-Registration packet welcoming you to our practice. Included in this registration packet will be forms that we ask to be completed PRIOR to your visit. A self-addressed, return envelope is provided for you to return this information to us in advance. When you arrive for your appointment our Patient Care Coordinator will ask you for your **current insurance card** and registration paperwork if you have not already returned it by mail. Information will include address, telephone number(s), social security number, birthdate, insurance information, employer information, emergency contact information, and other similar data. ***It is extremely important that this information is kept up-to-date.*** Accordingly, at each subsequent visit, our Patient Care Coordinators will verify most of this information when you present for your appointment. In the event that any of it has changed you will be responsible to advise us so we may update your records.

### **Health Insurance**

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If you will be using your health insurance to settle your account, you must present your **CURRENT** insurance card at each visit. This is a requirement of your insurance company. Your health insurance is a contract between you, your employer, and the insurance company. We are not a party of that contract. Not all services are covered in all insurance contracts. We have agreements with several insurance companies that require us to bill them for services provided to you, and accept as payment the amount specified in the agreement. You will be responsible for all amounts not paid by them, including amounts denied, applied to deductible, or considered non-covered. Although we work closely with insurance personnel and are updated regularly to changes in insurance policies, it is the patient's responsibility to provide insurance cards and updated referrals to our Patient Care Coordinators for all appointments.

- ***Co-payments and deductibles are to be paid at the time of your visit or your appointment will be rescheduled.***

We will file an initial claim based upon the information that you have provided to us. Under state law, your insurance company has 30 days in which to process and pay the claim, request more information, or deny the claim and notify us of the decision. If they have notified us your coverage has been terminated, the unpaid balance will be your responsibility.

**Should you have any question, please contact our office at 267-587-2066.**



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### **Vision Service Plan – VSP Members & EyeMed Vision Plan**

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We are Vision Service Plan (VSP) & EyeMed Vision Plan providers. We require that you notify us in advance of this coverage as we verify your coverage & our participation in your specific plan and obtain pre-authorizations for your visit.

**Should you have any question, please contact our office at 267-587-2066.**

### **Self-Pay**

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If you are self-pay, you will be expected to pay the day's charges on the day of the service. There may be additional charges for tests and other services rendered subsequent to your visit. If you are having a surgery, you will be expected to make mutually agreeable payment arrangements prior to receiving the service. If the service is considered elective (LASIK, refractive and cosmetic procedures), payment must be made in full to the services being performed. Personal checks & credit cards must clear prior to elective procedures.

**Should you have any question, please contact our office at 267-587-2066.**

### **Auto Insurance /Legal Claims**

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If you are seeing a physician as a result of an auto accident or other injury related to a legal claim against a third party, you will be considered self-pay. We will not file a claim with your auto insurance company or await a court settlement to be resolved.

**Should you have any question, please contact our office at 267-587-2066.**

### **Workers Compensation**

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Several of our physicians provide services under workers compensation plans. If you need to see a physician for an injury related to your employment, please have your employer or workers compensation case manager make the appointment. Should you make the appointment yourself, be advised we must confirm your injury with your employer before being seen. You will need to provide us with the case number as well as the address to which the bill is to be sent.

**Should you have any question, please contact our office at 267-587-2066.**

### **Personal Billing Statements**

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Patients with a personal balance will receive **one** personal billing statement with the current amount(s) due upon receipt. Further statements will not be sent.

**Any question, please contact our office at 267-587-2066.**



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### **Miscellaneous Forms**

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There will be a minimum processing fee of **\$15.00** for all complex forms requiring a doctor's signature. Please remember to bring all forms at the time of your visit. **Should you have any question, please contact our office at 267-587-2066.**

### **Past Due Accounts**

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Should your balance extend beyond thirty days of your initial statement date you may receive a courtesy collection call from our accounts receivable staff to resolve the amount. Should your balance extend sixty days or more past your initial statement date, collection procedures will commence. Past-due accounts cost both time and money; therefore, patients with delinquent accounts will be required to make payment at the time of service. If you are unable to make mutually agreeable payment arrangements, we will be glad to reschedule your appointment. Seriously past-due accounts or failure to make payments with agreed-upon payment terms may be sent to a collection agency. Should your account be sent to a collection agency you must pay all past due amounts or make agreeable payment terms before subsequent appointments can be scheduled. Additionally, patients can be dismissed from our practice for financial matters and will have to seek their health care elsewhere.

**Should you have any question, please contact our office at 267-587-2066.**

### **Billing Questions**

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**Questions or concerns regarding your account or insurance claim should be directed to our Insurance/Billing Coordinator at 267-587-2066 (direct). Our Insurance/Billing Coordinator has been empowered to make every effort to clarify any misunderstanding or confusion you may have regarding your account. Please notify us immediately if you feel an error appears on your statement or if you have any questions or concerns.**

### **Our Charges**

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At Total Eye Care Centers, PC we are committed to providing the best treatment for our patients, and the amount we charge for medical care is usual and customary for our area. Many insurance companies use a fee schedule that is derived from providers outside of our region, and the amounts will differ. Our fees will not be adjusted to meet your insurance company's usual and customary fees unless a contract exists between the insurance company and Total Eye Care Centers, PC.



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## **Uncancelled, Missed or No-Show Appointments**

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Your appointment time is reserved for your care. In the event that you must cancel or re-schedule, please give at least 24 hours notice (one business day) if you will not be able to keep your appointment. This will allow us the opportunity to offer your time to another patient. **In the event that you do not provide an appropriate notice, you will be charged \$25.00 for the missed or no-show appointment.** Payment of this fee is your responsibility and not a service reimbursed by your insurance.

## **Records Release**

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Should the need arise to have your confidential medical records released our **processing fee is \$25.00.** Allow five (5) business days for preparation and duplication. Appropriate HIPAA-compliant forms must be signed and personal photo identification is required.

**Should you have any question, please contact our office at 267-587-2066.**

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## **Accepted Forms of Payment**

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**Payment for services is your responsibility.**

**For your convenience, we accept CASH, PERSONAL CHECKS, MONEY ORDERS, VISA, MASTERCARD, AMERICAN EXPRESS & DISCOVER.**



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**CONFIRMATION OF NOTICE**      Account # \_\_\_\_\_

**\*\* Signed Form to be Kept on File in Patient Chart \*\***

**I understand the Financial Policies at Total Eye Care Centers.**

Patient Signature or Authorized Responsible Party:

\_\_\_\_\_

Patient's  
Name: \_\_\_\_\_

(Please PRINT Clearly)

Date: \_\_\_\_\_

\_\_\_\_\_

Date Updated: \_\_\_\_\_ Initials: \_\_\_\_\_

Date Updated: \_\_\_\_\_ Initials: \_\_\_\_\_

Date Updated: \_\_\_\_\_ Initials: \_\_\_\_\_

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