MEDICAL EYE SERVICES LTD FINANCIAL & BILLING POLICY

Thank you for choosing Medical Eye Services to serve your healthcare needs. We provide the best possible care for you and we want you to fully understand our financial and billing policy. We look forward to building a lasting relationship as your healthcare provider.

INSURANCE- We are a participating provider with many Medical Insurance Plans, however, we do not take Vision Plans. As a courtesy to you, we will bill your insurance company directly for medical services rendered. Prior to your visit, our office will verify your benefits, ultimately it is patient's responsibility to check with your insurance for any co-pays, co-insurance, deductible, out of network, usual and customary limit, per-authorization requirements or any other type of benefit limitation for services you might owe. Take in consideration that confirmation of benefits it is not a guarantee of payment. Payment is expected at the time of your visit.

If your insurance changed please notify our staff immediately and provide us your new Member Identification Card. On the contrary it could result in billing incorrectly holding you responsible for the full balance.

If you have primary coverage with Medicare please provide your Medicare or Medicare replacement card along with any additional medical coverage you may have. Billing to the incorrect insurance will result in insurance denying or not processing the claim making you responsible for services rendered.

If you have primary coverage with a Commercial Plan and secondary coverage with Medicaid, please note that we do not accept Medicaid in this instance and any balance or amount unpaid by the primary carrier will be patient's or patient's guarantor responsibility.

SELF PAY PATIENTS-Self pay patients are patients that have no insurance for our office to bill. As a courtesy, our office can extend a 10% discount of our fees. Payment in full is expected at the time of visit.

REFERRALS-All HMO plans require you to obtain authorization for services from your primary care provider. It is your responsibility to obtain this referral before you schedule an appointment. It is patient's responsibility to make sure such referral is valid and up to date. Failure to do so could result in Insurance denying services provided to you, holding you responsible for services rendered but not approved by your insurance.

OPTICAL GOODS- A 50% deposit is required at the time of order and the balance must be paid in full at the time of delivery for all contact lenses, contact lens supplies, glasses, and optical accessories.

COLLECTION ACCOUNTS-If a patient fails to pay their account balance after 90 days, a patients' account will be sent to an outside collection agency. If your account goes to collection it will be necessary for you to pay the account in full before receiving any further care.

RECORD COPY FEES – There is a fee for anyone requesting their medical records. Our office fee schedule for copy fees goes along with the State of Illinois Record Copy Fee Guidelines. These fees change every year. We will inform you of the fee before we copy your records.

Most medical insurance plans, including Medicare, do NOT cover routine refraction or routine eye examinations.

Our office fee for a refraction is $ 50 and this fee is collected at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly

____________ I have read the above information and understand that **the refraction is a non-covered service**. **I accept full financial responsibility for the cost of this service and understand it is due at time of service.** I understand that any co-payment, coinsurance, or deductible I may have are separate from and not included in the refraction fee, as well as I comply with Medical Eye Services LTD billing policy.

__________ I decline the refraction service today. I understand that without the refraction, my doctor may not be able to fully assess the health and function of my eyes.

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Print name of Patient

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Signature of Patient (or responsible party if minor) Date