The Eye Care Group

Effective Date: July 1, 2015

THIS NOTICE DESCRIBES OUR FINANCIAL/OFFICE POLICY. PLEASE REVIEW IT CAREFULLY.

WELCOME: The providers and staff at The Eye Care Group would like to welcome you to our practice. We strive to provide you with excellent care and communication. If you have any questions about financial matters, please ask prior to any service being rendered.

AFFIRMATION: By signing below, you confirm that you have read and understand our Financial Policy, and you further understand and acknowledge that is your responsibility to inform our office of any change in insurance, payment arrangements, address, or telephone number.

INSURANCE: If you have vision or medical insurance, we want to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy. You will be asked to update your demographic and insurance information annually, including providing our office with copies of your insurance cards, both vision and medical. We are required to obtain your signature for permission to release information to your insurance carrier annually. Our failure to obtain these updates could result in criminal and civil penalties and/or expulsion from your insurance plan. Please assist us in complying with your insurance requirements. We will gladly submit fees for your covered medical services to your insurance company. However, we expect payment of all services within 60 days. It may become necessary for you to pay your account in full if your insurance company fails to pay for services within 60 days. It is your responsibility to understand your coverage and benefits, including pre-certifications, referrals, and authorization requirements. We, however, will assist you to ensure all plan requirements are met. *While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.*

PAYMENT FOR SERVICES: Payment for services, including co-payment and deductible amounts, is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. Our failure to collect these would be a violation of our contract with your insurance company and may result in civil and criminal penalties and/or expulsion from your insurance plan. In addition, your failure to pay the required co-amounts is a violation of your financial responsibility for coverage and we may report your refusal to pay these amounts to your employer and/or insurance company representative. We accept cash, checks, MasterCard, Visa, Discover, and Care Credit.

Divorced/Separated parents: The parent bringing the child in for services is responsible for any charges, fees, co-pays, or deductibles due. We will NOT second party bill. The Eye Care group will not act as a mediator between parents. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

APPOINTMENTS: If you do not have your payment, your appointment may be rescheduled. You may be asked to schedule another appointment for issues other than the reason for your original appointment. You may be asked to reschedule your appointment if you arrive after your scheduled appointment time. We ask that you kindly give a 24 hour notice if you need to reschedule or cancel an appointment. If you do not show for your appointment on three occasions, we reserve the right to dismiss you from our practice.

PATIENT ACCOUNT: Refunds will be issued within 60 days after your written request, and

only if there are no pending insurance claims on your account. Any unpaid balances 60 days or older may result in being turned over to a collection agency and/or your dismissal from the practice. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in management of your account. If you have any questions on the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. Returned checks, account balances older than 60 days, and failure to pay account balances as promised may be subjected to external collection and additional collection fees, including attorney and other court fees. I hereby agree to a late fee of $20 for balances less than $100 and a fee of $50 for balances $100 or more, if my account goes past 60 days and The Eye Care Group/Lisle Family Eye Care has to incur charges to refer my accounts to a collection agency to collect the debts. I hereby agree to pay reasonable attorney fees and court costs charged in preparing, filing and obtaining a judgment against me, in addition to attorney fees charged in collecting upon obtaining a judgment by way of a proceedings supplemental, garnishment or any other reasonable post –judgment collection method. **If any member in your household has a balance in collections, those balances must be paid in full along with the collection fees before you are seen.**

CONTACT LENS AGREEMENT: Please review and sign if you are a current contact lens wearer or interested in trying contact lenses and wish to be fit in contacts or receive a contact lens prescription. In order to provide you with the contact lenses that give the highest quality of vision, health and comfort, we require certain additional contact lens procedures that are charged separately from a routine eye examination. Patients that require a contact lens prescription may be responsible for the examination fee, refraction fee, and contact lens fitting fee. It is not always possible to determine in advance if a person will become a successful contact lens wearer. New and established fees range from $60 to $90 depending on the type of contact lenses your prescription requires. This does not include the cost of the contact lenses. This additional fee includes a specific evaluation of the corneal health, the movement of the contact lens on the eye, and may include a class for new contact lens wearers that will teach insertion, removal and care of the contact lenses. This is a non-refundable charge and does include up to 3 thirty minute classes. Your contact lens prescription is valid for one year. By law we cannot exceed one year. We will try to help any of our patients with emergency needs, but we will not continue to provide contact lens trials excessively. If we feel that this policy is being abused, we reserve the right to deny contact lens trials.

Contact lens returns must be unopened and within 30 days of purchase.

EYEGLASS POLICY : You have 30 days from the date you pick up your eyeglass order to decide if the prescription is going to work for you. If within 30 days, you feel your prescription is not correct we will recheck your prescription and remake your lenses (if necessary). There will be no additional cost, unless the change in prescription is medical in nature. If the change in your prescription is due to medical reasons, your

medical insurance will be billed, and you will be responsible for any co-pays, co-insurance and/or deductibles. If you come in past 30 days you will be required to pay at least a refraction fee and will be responsible for the cost of new lenses. We do not exchange frames once they leave this office. When picking out frames, make sure that they are the pair that you are going to want. If you decide that you didn't want your glasses after ordering them, and our lab has started on your job, a refund will not be given. Due to limited space, we only hold materials for 30 days unless you have already made prior arrangements with us. If you have any questions regarding this policy, please feel free to ask any of our staff and we will be happy to assist you.

My Signature below constitutes acknowledgment and acceptance of this ENTIRE office policy.

Signed: _____ Date: _____

(Parent / Guarantor or Patient)

MEDICARE ONLY I request the payment of authorize Medicare benefits to be made on my behalf to **The Eye Care Group** for services furnished to me by **The Eye Care Group**. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits and pay the submitted claims. If other health information is indicated in item 9 of the CMS 1500 form or elsewhere in other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. **The Eye Care Group** accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of Medicare carrier.

Signed: _____
Date: _____