HORIZON EYE SPECIALISTS & LASIK CENTER - FINANCIAL POLICIES

PATIENTS OF CONTRACTED (IN-NETWORK) HEALTH INSURANCE PLANS:
If our office is contracted with your health care plan, we will submit your claim to your carrier. You are expected to pay your co-pay at the time of service, per your contractual agreement with your insurance carrier. **United Healthcare Group Medicare Advantage** policy holders are required to pay a co-pay at every visit including post-operative visits.

You are responsible for all services provided by our office which are not covered by your insurance. Please contact your insurance company in advance to verify coverage for benefits such as refractions, contact lens exams and routine eye care and any deductibles that may apply.

PATIENTS WITH NON-CONTRACTED (OUT-OF-NETWORK) HEALTH INSURANCE PLANS:
You are responsible for payment in full at the time of service if our providers are not contracted with your insurance plan. We will provide you with a paid receipt for you to submit directly to your insurance for reimbursement. As a courtesy, and upon request, we will file your insurance claims providing payment is **made in full at the time of service.** In this case, the insurance company will reimburse you directly for your paid claim. Refraction/check for glasses is not a covered benefit under most insurances. The refraction charge is **$65.00**; you are responsible for payment of this at the time of service.

PATIENTS THAT HAVE INSURANCE PLANS THAT REQUIRE A REFERRAL:
As a practice, we will do our very best to inform you about your insurance benefits. There are times when we are not provided with the most up to date copies of insurance cards. **If you have a plan that requires a referral, you are responsible for obtaining that referral directly from your PCP.** Failure to do so can result in denied insurance claims to which you will be responsible for paying.

PATIENTS WITH NO INSURANCE BENEFITS:
You are responsible for payment in full at the time of service.

ALL PATIENTS OF OUR PRACTICE:
Please bring your insurance cards with you and keep our office informed of any changes in your insurance, address, telephone, or employment. For your convenience we accept Debit Cards, Mastercard, Visa, Discover, American Express, Checks and Cash.

Insurance issues, requirements and coverage are ever changing. We are making every effort to comply and to eliminate payment denials before they occur. Your insurance plan *may* or *may not* cover routine eye services.

We are legally obligated to assign procedure codes based on the services provided to you, whether it is routine eye exam or a visit to take care of problems or both. We cannot change the coding later to cause the insurance company to pay for a non-covered service.

Based on the kind of coverage you have, some or all the cost may have to be billed to you.

DELINQUENT ACCOUNTS:
Accounts greater than 90 days past due are subject to collection and associated collection fees. If your account is considered subject to **collections, an additional 40%** of your total amount owed will be added to your balance.

Misc Forms:
Requests for form completion i.e., FMLA, driver's license, disability forms etc, are subject to a $30.00 fee. **The fee for a returned check is $35.00.**

Acceptance, Consent for treatment, release of information, financial agreement & assignment of benefits:
I have read and understand the financial policy and agree to abide by the terms of this policy. I or my representative, recognizing the need for care, consent to all and any services as ordered by my physician, including, but not limited to, laboratory tests, medical or surgical treatment examination, and other services rendered under the specific instructions of my physician.

Although this office may assist me in filing any insurance claims, I understand that I am fully responsible for the balance and agree that payment will not be delayed because of any pending insurance claim. I authorize all insurance benefits, unless previously paid by myself, to be paid directly to this physician and I also authorize the provider to release any information needed for payment of claims.

Patient Name:_____

Account: _____ _____

Signature of Patient or Legal Guardian

Date:_____