FINANCIAL POLICY

The fees charged in our office are directly related to the complexity of your problem and the resources devoted to your diagnosis and treatment. Our doctors are participating providers with Medicare and many commercial insurance carriers. Medicare assignment is accepted for all covered services. Due to the many changes in insurance policies, we cannot be responsible for interpreting each & every policy. We will verify that you have a current & active insurance policy only. Therefore, we urge you to please check with your insurance company regarding the specifics of your individual coverage, including co-insurance, copays, and deductibles, as well as who is an authorized provider for your plan. We request payment of the 20% Medicare co-insurance and any deductibles or co-pays at the time of your visit.

Refractive surgery and cosmetic procedures are usually not covered by Medicare and most insurance companies. Please ask our financial counselors about payment options for these procedures.

Referrals & Non-Participating Provider Policy
If you need a referral from your insurance company or from your primary care physician to be seen in our office, we must have the referral at the time of your visit. You are responsible for obtaining the referral. If you do not have a referral you will need to reschedule your visit. If we are not providers for your insurance company, we will need to collect the fee for the visit at the time of service.

Medicare
We accept assignment but you must understand that you are still responsible for the yearly deductible as well as the 20% co-insurance. There are also a number of non-covered Medicare services (i.e. refractions) that you will be responsible for. Make sure you understand your insurance and Medicare coverage limits.

PPO/POS
Your co-pay must be paid at the time of service.

We accept Cash, Checks, MasterCard, Visa, American Express and Discover.

A fee of $50.00 will be charged for any returned check.

THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS.

I have read the Financial Policy & I agree to it.

Patient Signature_____ Date_____

Printed Name_____