

GEORGIA EYE SPECIALISTS

FINANCIAL POLICY

Patient Name _____

We are committed to meeting your healthcare needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost effective manner, we ask that you adhere to the following guidelines.

1. You are ultimately responsible for payment of charges for services you receive from our office. Any check payment dishonored by your bank will result in a **\$40.00 return check charge** being added to your account.
2. Please provide us with your current address, telephone number, and insurance information. It is very important that we have current information on you as we may need to contact you in case we need to mail you test results or other information. Although we realize it is inconvenient, please be prepared to update your information frequently.
3. It is your responsibility to contact your insurance carrier to confirm that our physicians participate in your plan. If you see a doctor that is not currently on your plan, you will be responsible for payment in full.
4. If your plan requires a referral, it is **your responsibility** to obtain this prior to being seen by the doctor.
5. Your copay is due at EVERY visit and will be collected prior to your being brought back to the examination area. There are no exceptions to this policy. Please direct any questions regarding this policy directly to your insurance company. If there are additional charges such as checking glasses, *deductibles*, or other services, these will be collected upon check-out. Please be prepared to pay for these services at the time they are rendered. There is a billing charge of \$10 for deductibles to cover the billing process. We appreciate your help in keeping our costs low by avoiding unnecessary billing charges. We can NOT bill for refractions and co-pays which are due at the time of service.
6. We would greatly appreciate if you could give 24 hour notice if you are unable to keep your appointment. This allows us to offer this time to another patient who needs to be seen. If you do not give 24 hour notice, a charge of \$25 will be applied to your account.
7. All medical records release requests must be in writing. As per HIPAA guidelines, your records will be released within 30 days. There is a per page charge for copying your records in accordance with Georgia state law. If you need them sooner than 30 days, there may be an additional charge of \$25. We will make every attempt to release records quickly but can not always release them immediately. We do not release records on a walk-up basis as our first responsibility is to take care of patients being seen today. Similarly, there is a charge for any forms or dictated letters you request. Forms take at least 2 weeks to process and will not be available immediately.
8. Glasses or vision exams for the purpose of prescribing, fitting, checking, or changing glasses or contacts are not covered by Medicare and most private insurances. Therefore, examinations for glasses or contact testing are expected to be paid in full at the time of service.
9. In the event the balance on your account becomes 60 days delinquent after insurance payments, your account may be sent to our collection agency. You would be responsible for the collection fees incurred.
10. Life is full of changes. Please be prepared to show us your insurance card AT EVERY VISIT so we can be prepared for possible changes in your coverage.
11. Ultimately, you are responsible for your medical bills in our office, and we can not interfere in payment problems or disputes between you and your insurance company. If no payment is received from your insurance company within 30 days, the amount becomes your responsibility and you may seek reimbursement from your insurance company after you have paid us.
12. If you have questions or concerns about any of these policies, please direct them to Denise and not to the front desk.

Patient Signature _____ Date _____