LA PINE EYECARE CLINIC

16410 THIRD Street, Ste A
La Pine, OR 97739
T:541-536-2911 **F:**541-536-2913

Financial Policy

Insurance Patients:

As a courtesy, our office will file your insurance claims and assist you in obtaining the maximum benefits specified in your insurance plan. We will ESTIMATE your fees due based on information provided to us by your insurance company. Your estimated portion of fees is due at the time of service. It is your responsibility to understand your insurance coverage and benefits. We cannot guarantee payment by your insurance company. Every insurance plan is different and may have specific exclusions and other restrictions unknown to the clinic. Any portion of fees billed to your insurance company that are not paid for any reason will be billed to you. Our office will send you a statement with the amount you owe and this amount is due upon receipt.

Medicare Patients

Medicare does not cover any services unless deemed medically necessary. **The refraction portion of the eye exam, which is $25.00, is always deemed NOT medically necessary**. Medicare also requires you to pay a co-pay of twenty percent (20%) of the allowed charges. This co-pay is sometimes picked up by your secondary insurance. Please specify at the time of you visit if you have a secondary insurance. We will collect fees and co-pays for test and services not covered by Medicare at the time of service. You will receive a statement for billed services that Medicare does not cover. Please pay this amount due in a timely manner.

Cash Paying Patients (Non-Insurance)

Payment is expected at the time of service. We do offer a discount on routine eye exams and a 20% discount on other medical eye services for cash paying patients. We accept cash, checks, Visa, MasterCard and Discover as well as Care Credit. Any check returned by your financial institution for any reason will be assessed a charge of $25.00.

*The cost of any date of service is not complete until the finished documentation of that visit is reviewed for accuracy. Any account over sixty (60) days delinquent will be sent to a collections agency, as well as assessed a late fee of thirty percent (30%) of the balance to cover associated costs.

*If making payment arrangements, your balance is not paid off within six months, the account will be accessed an interest charge at the rate of 18% and will be outsourced to HealthFirst Receivable Outsourcing (HeRO).

I have read the above financial policy and agree to the terms outlined. I understand that I am responsible for all charges of services provided to me, including the balance remaining after reimbursement by my insurance company. I also authorize release of any information concerning my (or my child's) health care for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits otherwise payable to me to be paid directly to the doctor for services rendered.

Signature: _____ Date: _____

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