La Pine Eyecare Clinic

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 benefits quoted by your insurance company or final payment of claims. 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 (determining your glasses prescription), which is a $25.00 charge, is always deemed NOT medically necessary**. Medicare also requires you to pay a co-pay of twenty percent (20%) of the allowed charges, as well as a yearly deductible if not yet met. This co-pay and your deductible is sometimes picked up by your secondary insurance (Medicare supplement plan). 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 the amount you owe for billed services that Medicare does not cover. Any amount owed is due upon receipt of your statement.

Cash Paying Patients (No Vision or Medical Insurance Coverage)

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 paid at the time of service. 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 (Professional Credit Service), as well as assessed a late fee of thirty percent (30%) of the balance to cover associated costs.

*If making payment arrangements, and your balance is not paid off within ninety (90) days, the account will be accessed an interest charge of eighteen percent (18%) of any amount still owed and will be outsourced to HeRO Outsourcing, Inc.

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 La Pine Eyecare Clinic for services rendered.

Signature: _____ Date: _____