Griffith Eye Center, PC

We are committed to provide you with timely, appropriate and cost effective health care and to provide treatment that leads to the best outcomes in a friendly, professional and patient-focused setting.

FINANCIAL POLICY

We want to ensure that you receive your maximum insurance benefits available. In order to achieve this goal, we need your assistance and understanding of our financial policy. We ask that you read and sign the following to acknowledge that you have been advised of your responsibility for services/products provided by our office.

PAYMENT FOR SERVICES:

- **Payment is due at the time of service.** We accept cash, check, debit card, Visa, MasterCard, Discover, American Express and Care Credit.
- As a courtesy to you, our office will bill your insurance company for services rendered. You must provide us with your correct and up-to-date insurance information, prior to or at the time of service, including: **Insured's full name; Date of birth**; **Social Security Number, Address; Employer. We *cannot* file claims for your services, or check your benefits, without this information.**

INSURANCE BENEFITS:

- Prior to your appointment we will check your insurance benefits, provided that you have supplied us with this information. This information enables us to **ESTIMATE your out-of–pocket expenses (the portion not covered by insurance) for services that will be provided.**
- At the time of service, an **ESTIMATE of benefits** is made based on the information provided by your insurance carrier. This is **NOT A GUARANTEE OF PAYMENT**. When payment is received from your insurance company it will be applied to your account. Any balance due will be billed to you. Any overpayment will be refunded to you. **Please be aware that you are responsible for your total obligation should your insurance benefit result in less coverage than anticipated**.
- Your insurance policy is a contract between you and your insurance company. **You are ultimately responsible for payment** should they not pay.
- If, for any reason, your insurance company rejects payment for services rendered, the bill becomes your responsibility.
- It is important that you respond to any request from your insurance company or our office so that payment is not delayed.
- If your insurance policy has a deductible and you have not met your deductible for the year, you may be required to pay the deductible balance due at the time of service.
- It is **your responsibility** to know if we are participating providers in your insurance plan. We try our best to keep up with changes in insurance plans but it is **your responsibility** to know what they will and will not pay.
- If you cannot provide proof of insurance at the time of service, you will be considered self-pay and you will be required to pay for services at the time of service.
- It is **your responsibility** to inform our office of any changes to your insurance throughout the year.
- If your insurance company requires a referral to see a specialist, it is **your responsibility** to notify your primary care physician prior to your visit with us. If the referral is not received, the bill becomes **your responsibility.**

CO-PAYMENTS:

- **All co-payments for office visits are due at the time of service.**
- Our contract with your insurance company requires us to collect your co-payment at the time of service. There are no exceptions. If you do not pay your co-payment at the time of service, and we have to bill you, a $5.00 billing charge will be added to your statement.

OVER

TESTING:

- If you are being treated for a medical condition, the doctors may initiate diagnostic testing to further evaluate and treat your condition. The testing may include: visual field tests; OCT tests; fundus photos. These tests are separate services from the medical eye exam and will be submitted to your medical health insurance. It is **your responsibility** to know if your insurance covers diagnostic testing and to inform the doctor or staff **before the testing is done**. If your insurance denies the service, the bill becomes **your responsibility**.

MEDICAL HEALTH INSURANCE VS. VISION INSURANCE:

- It is **your responsibility** to inform us what insurance you intend to use for your visit **at the time of your visit.**
- We are a medical office. Our standard exam is a medical eye exam in which we bill your medical health insurance.
- If you are here for a routine eye exam with refraction (or vision exam), it is **your responsibility** to inform the staff and doctor **before the exam** that you intend to use your vision insurance. The doctor will perform a vision exam and the service will be submitted to your vision insurance.
- The doctors will not treat any medical complaints or findings during a vision exam. You will be informed that there is a medical condition that requires a subsequent visit. You will have the option to have the medical condition addressed during this visit, in which case your medical health insurance will be billed instead of your vision insurance.
- If the reason for the eye exam is a medical condition, the service will be submitted to your medical health insurance and you will be responsible for any co-pays and deductible balances associated with your medical health insurance.

MEDICARE PATIENTS:

- Medicare does not pay for refraction (refraction is the measurement done to see if you require a change in your lens prescription). There is a $30.00 charge for refraction and payment is due at the time of the service.
- If you do not have a secondary insurance to Medicare you are responsible to pay the 20% balance that Medicare does not cove. This is due at the time of the service.
- If you do not pay your $30.00 refraction charge or your 20% balance at the time of service and we have to bill you for these services, a $5.00 billing charge will be added to your statement.

FORMS / LETTERS:

- There is a $5.00 charge for each form or letter that you request. Payment is due when the form or letter is requested.

STATEMENTS:

- You will receive a monthly statement if you have a balance due to our office. Full payment is due by the due date on the statement.
- If payment is not received within the billing cycle, or if the balance is not paid in full, your account will be accessed a $5.00 billing charge.
- Past due balances are referred for collection. If you have a balance in collection it must be **paid in full** before any additional services can be rendered. If you have been on collection previously you may be required to pay for services in full at the time of the service. You may be responsible for submitting to your insurance for reimbursement.
- We accept cash, check, debit, Visa, MasterCard, Discover and American Express and Care Credit.
- There is a $30.00 charge for all returned checks.

I have read and I understand the financial policy of Griffith Eye Center as explained above. I agree to be responsible for the payment of any services and products provided to me by the doctors and staff of Griffith Eye Center.

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Signature of patient or responsible party Date

Thank you for choosing Griffith Eye Center for your eye health care.

YOUR VISION IS OUR MISSION.