Avery Eye Clinic

Board-Certified Medical and Surgical Ophthalmologists
Fellows of the American Academy of Ophthalmology

Baptiste J. Dejean, III, M.D., F.A.C.S.
Craig C. Kuglen, Jr., M.D.
Linda H. Lin, M.D.
Mark H. Wilkerson, M.D.

Brian C. Au, M.D.
Andrew W. Dvorak, M.D.
Renee E. Williams, O.D.

AVERY EYE CLINIC FINANCIAL POLICY

At Avery Eye Clinic, we believe that all patients who come to this office deserve the best medical care and service available. For us to provide you with the highest quality eye care with current technology, we must meet the expenses necessary to operate this facility. To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with the Billing Supervisor.

DEFINITIONS

- *In-Network/Participating Insurance:* These are insurance companies with whom we have a contractual agreement. If we are "in-network", we have agreed to a discounted rate with the insurance company for its members
- *Out of Network/Non-Participating Insurance*: These are insurance companies with whom we do not have a contractual agreement. If we are not "in-network" with your insurance carrier, and you do not have "out of network" benefits on your policy, we will not bill your insurance carrier and you will be considered a "Self-Pay" patient, responsible for all services rendered on your visit. We will be happy to give you an itemized receipt from your visit so that you may file a claim with your insurance company.
- *Accept Assignment:* We agree to accept payment from your insurance company for services rendered. You will still be responsible for any deductible, copay, and/or coinsurance amounts at the time the service is rendered.

SELF-PAY PATIENT: We offer discounted rates for patients without insurance or with "out of network" insurance that have no out of network benefits. We do ask for a credit card, check, or cash deposit of the expected charges payable at check in, to secure your appointment. Any additional charges or reductions will be calculated at check out, and either collected or refunded, as needed.

PAYMENT AT TIME OF SERVICE: As a courtesy, we will bill your insurance for office visits. However, we ask that you pay any portion that we have reason to believe will not be covered by your insurance (i.e. deductible, copay, coinsurance, non-covered services). Full payment is due on the day of service.

REFERRAL: If you did not obtain a required referral or authorization from your insurance company or primary care physician and one is required, you will be responsible for all charges.

MEDICARE PATIENTS: If you have Medicare as your primary insurance, but no secondary/supplemental insurance, then you are responsible for the Medicare deductible and coinsurance at the time of service.

PAYMENT OPTIONS: Avery Eye Clinic accepts cash, check, all major credit cards, and Care Credit. There is a $25 fee for all returned checks.

(over)

MEDICAL RECORDS: A copy of your medical records is available to you at your discretion. A medical records release form must be filled out and signed by the patient prior to the release. The fee for medical records preparation and copying is $25.00.

SUBMISSION OF CLAIMS: Avery Eye Clinic will submit your insurance claim on your behalf; however, it is important to understand that your insurance is a contract between you and your insurance company. Although we file insurance claims as a courtesy to you, ***you are still responsible for all charges not paid by your insurance***, such as deductibles, copays, coinsurance, and non-covered services.

Your medical insurance plan will only pay for services that it defines as "reasonable and necessary." If your carrier determines that a particular service does not meet its criteria under program standards, your plan will deny payment for this service. In the event that your insurance carrier determines a service is "not covered," you will be responsible for the complete charge for that service.

BALANCE DUE AFTER INSURANCE PAYS: Patients will receive a statement with any outstanding balance once all applicable insurance companies have responded and payments have been posted. If a balance is due after your insurance carrier pays, payment is due upon receipt of a statement from our office. Payment arrangements may be made for special circumstances by contacting the Billing Supervisor within 30 days of receipt of the invoice. ***It is your responsibility to contact our office to make special arrangements***

REFRACTIONS: Medicare, Medicaid, and most commercial insurance plans do not cover refractions. Medicare and Medicaid only reimburse for services that they deem ***medically*** necessary, or are benefits of special preventive and screening programs. Refraction (CPT 92015) is a non-covered benefit as it is considered "routine" in nature. The fee for this test, when necessary, is $40.00. If your ophthalmologist determines that you need to have a refraction performed and your insurance is one that does not cover it, you will be responsible for paying that portion of the exam fee, along with any other fees you are normally responsible for (i.e. copayments/deductibles).

"I understand that, in the opinion of my ophthalmologist, the service listed above and provided to me may not be covered under my commercial insurance, Medicare, or Medicaid as reasonable and necessary for my care. I understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be a covered benefit." **X** _____

(Patient/Responsible Signature)

LATE CANCELLATION/NO-SHOW: Should you need to cancel or rescheduled an appointment please contact our office as soon as possible, but no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Late cancellation/no-show may result in a $25.00 fee for the first occurrence, increasing to a $50.00 fee for any subsequent occurrences, and review for dismissal as a patient of Avery Eye Clinic. The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit**. If there are extenuating circumstances for why you are unable to give the minimum 24-hour notice, please contact our Front Office Supervisor to discuss.

I have read and understand the Avery Eye Clinic financial policy and I agree to be bound by its terms. I also understand and agree that Avery Eye Clinic may amend such terms at any time.

_____ _____

Signature of Patient or Responsible Party
(if pt is a Minor)

Date

_____

Printed Patient Name