Specialized Pediatric Eye Care & Adult Strabismus

## PAYMENTS / NO SHOWS / CANCELLATION POLICIES

1. **Insurance:** We participate with ***most*** major insurance plans, including Medicare. If you are not insured by a plan, payment in full is expected at the end of each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full may be required until we can verify your coverage. Knowing your insurance benefits is ***your*** responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-Payments and Deductibles:** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. If you are unable to pay at the time of service, your appointment may be rescheduled.
3. **Non-Covered Services:** Please be aware that some-and perhaps all- of the services you receive maybe non-covered or not considered medically necessary by Medicare or other insurances. You must pay for these services in full at the time of your visit.
4. **Proof of Insurance:** All patients must complete our patient information forms before seeing the provider. We must obtain a copy of a current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.
5. **Claim Submission:** We will submit your claims and assist you in any reasonable way we can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Insurance Changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
7. **Divorce / Separation:** In case of divorce or separation, the party responsible for payment on the account is the parent authorizing treatment of the child. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. We do not forward bills to other parties regardless of court rulings or divorce decrees.
8. **Returned Checks:** If the bank imposes a fee for a returned check, that fee will be passed on to the patient.
9. **Non-Payment:** If your account is over 90 days past due, we may refer your account to a collection agency.
10. **No Show / Cancellation:** If you must cancel or reschedule an appointment, we kindly ask that you call as soon as you can, preferably at least 24 hours before your scheduled appointment time. Failing to show up for your appointment is considered a "no show." After 3 "no shows", it is our policy to discharge the patient from the practice.

I have **read and understand** the payment policy and agree to abide by its guidelines.

_____ _____/_____/_____

Print Patient Name Date of Birth

_____ _____/_____/_____

Signature Date