OHIO
OPHTHALMOLOGY

Financial Policy

Thank you for choosing Ohio Ophthalmology, Inc to provide your ophthalmic services. We are committed to providing you with exceptional care. A good physician and patient relationship relies on good communication and understanding of what is expected of both. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services. Please read and sign prior to your appointment with our office.

Payment for Services:

- We accept cash, check, Visa and MasterCard. If you are having surgery, the facility and anesthesiologist are separate providers. Payments for those services must be discussed with the hospital or surgery center where the services will be performed. We can provide you with those phone numbers.
- We bill medical insurances only. If you have insurance with a plan with which we do not participate, you will need to pay in full at time of service.
- If you do not carry medical insurance, we offer self-pay discounts. We cannot apply self-pay discounts if you carry medical insurance, regardless if we participate with your insurance company.
- Returned and NSF checks are subject to a $25.00 additional fee. Returned checks must be resolved before any appointments can be arranged.
- If you are seeking a non-covered service, we require that you be prepared to pay our fees in full at the time of service.

Insurance:

We must emphasize that our relationship is with you, not your insurance company. We will appeal disputed claims; however, if a claim remains unpaid by your insurance company the bill will become your responsibility. We file insurance claims as a courtesy, but all charges are your responsibility.

- Be familiar with the requirements of your specific plan.
- Present your insurance card at each visit.
- Pay copays, co-insurance and or unpaid deductibles at the time of service.
- If you have two insurances, we will be happy to submit one (1) claim with your secondary carrier. If we do not receive payment from the secondary carrier within forty-five (45) days, we will transfer the balance to you and you will be expected to pay the remaining balance.
- If we are not a participating provider with your insurance, you will be responsible for payment in full at the time of service.

- If your insurance requires a referral, you are responsible for contacting your primary care provider to obtain the referral. If your plan requires a referral and a referral is not on file, you will need to reschedule your appointment with our office or pay in full at the time of service.
- If you have questions about your coverage, please contact your insurance member services.

Non-Medical Forms:

- There will be a minimum charge of $25-payable in advance- for completing disability forms. Additional fees may be charged.
- We may charge a fee for the release of medical records.

Delinquent Accounts:

- If you fail to pay your bill or not follow through on a payment plan, your outstanding balance may be sent to an outside collection agency.
- If your account is sent to an outside collection agency, you will be responsible for the fees assessed by the collection agency in addition to your account balance.
- No further visits will be scheduled until the delinquent balance is paid in full.
- If payment is not received, we may discharge you from our practice.

Coding and Billing:

- This office can only code and file claims for procedures and diagnoses that are truly encountered and appropriately documented in the medical record.
- We will not change a medical record solely for the purpose of obtaining reimbursement from an insurance carrier.

No shows and cancellations:

- If you are unable to keep an appointment, we ask that you notify our office at least twenty-four (24) hours in advance so that we may see another patient at your scheduled time.
- You will not be charged for cancelled appointments.
- You may be charged for failure to show for an appointment. Multiple failure to show may result in dismissal from our practice.

Please sign below that you have read and understand our Financial Policy. Please let us know if you have any questions or concerns.

I have read and understand the above policies. I understand that my insurance carrier may assign benefits to Ohio Ophthalmology or my insurance carrier may make a payment directly to me. I understand and certify that if any insurance payments are made directly to me, I am financially liable

and agree to immediately pay Ohio Ophthalmology charges for health care services provided to me or any of my dependents in addition to any co-pays, deductibles, co-insurance amounts, or amounts for non-covered services.

I also certify that I am responsible for and will immediately pay any amounts not paid by insurance because I failed to provide accurate and/or complete billing information.

Signature of Patient or Responsible Party Date