Byron Eye Care

Patient Financial Policy

Thank you for choosing Byron Eye Care as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. name, address, phone numbers, insurance information, etc). **Any information provided to our office may be used in proper care or collection by our office or by our business partners.**

Co-pays

The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check or credit cards. Post-dated checks will not be accepted.

As a courtesy to you, we are happy to file your insurance claim, however, it is not our responsibility to know what limitations, exclusions, deductibles or copays each group insurance plan might leave to a patient's responsibility.

Insurance Claims

Insurance is a contract between you and your insurance company. In most cases, we are not a party of this contract, but we will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Self-pay Accounts
Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. Liability cases will also be considered self-pay accounts. We do not accept attorney letters or contingency payments. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven.

Workers' Compensation
It is the patient's responsibility to provide our office staff with employer authorization/contact information regarding a workers' compensation claim. If the claim is denied by the workers' compensation insurance carrier, it then becomes the patient's responsibility. At your request, we will submit the claim to your primary medical insurance carrier with a copy of the workers' compensation insurance denial. If your primary medical insurance carrier's claim is denied, you will be responsible for payment in full.

Missed/Cancelled appointments

We would appreciate your help and the courtesy of a call if you are unable to keep an appointment. Please notify our office at least 24 hours prior to the appointment time. We reserve the right to charge a missed appointment fee of $25.00 for each appointment that is not canceled in a timely manner.

Late Cancellations: A late cancellation is considered when a patient fails to cancel their scheduled appointment with a 24 hour advance notice.

No-shows: a no-show is when a patient misses an appointment with no notice or shows up too late to the appointment to be seen.

A **$25.00 fee** will be billed to your account for late cancellations and for no-shows.

Repeatedly missing visits jeopardizes your care. For this reason ***after an ESTABLISHED patient has two (2) late cancellations and/or no-shows or a NEW PATIENT has one (1) cancellation or no-show, after which, they may be discharged from the practice. Repeated cancellations or no-shows may result in discharge from the practice.***

Returned Checks
The charge for a returned check is $40 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Minors
The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors. A minor is defined as a patient under 18 years of age.

Outstanding Balance Policy
An account is considered past due 30 days following billing unless other arrangements have been made. Unpaid accounts beyond 90 days are considered delinquent and may be forwarded to a collection agency. Delinquent accounts also may be subject to additional fees and/or finance charges by our practice or the collections agency.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections and all associated fees including attorney fees and court costs.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

Signature

I have read, understand and agree with the terms detailed in this policy.

Patient Name *(please print)*: _____

Signature_____

Date_____

Relationship to Patient if minor *(parent, guardian, etc.)* _____