

MID FLORIDA EYE CENTER'S FINANCIAL POLICY

Thank you for choosing Mid Florida Eye Center as your health care provider. Our doctors and staff are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance and your understanding of our Financial Policy. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy that we require you to read and sign prior to any treatment.

- ◆ All patients must complete our Information and Insurance form before seeing the doctor.
- ◆ Full payment is due at time of service.
- ◆ We accept cash, checks, or Visa/Mastercard. By Law we may charge a reasonable fee for returned checks, currently that fee is \$20 per returned check.

PARTICIPATING HEALTH CARE INSURANCE PLAN OBLIGATION

Mid Florida Eye Center maintains a list of the health care service plans with which it has contracted to provide services to patients. We have agreed to bill those insurance carriers for all services rendered. Authorization from your insurance company does not always guarantee full payment. The undersigned and/or patient shall remain responsible for all charges, applicable co-payments, and deductibles. If your insurance has not responded to our claims submittal within 60 days, payments for services incurred and claim status follow-up becomes the responsibility of the patient.

NON-PARTICIPATING INSURANCE

All fees are due in full at time of service. A receipt is provided which details all services and payments for the visit. A copy of this receipt can be submitted to your insurance carrier for you to receive payment.

PPO/HMO/MEDICARE/TRADITIONAL INSURANCE WAIVER REGARDING NON-COVERED SERVICES

Medicare, (under section 1862 (a) (1) of the Medicare law), and some health insurance plans will only pay for services that they determine to be "reasonable and necessary". If they determine that a particular service is not "reasonable and necessary" under their program standards, or that the services are unauthorized, or not a covered benefit under your plan, Medicare and other insurance plans will deny payment for those services. Based on past insurance Explanations of Benefit statements, payment is sometimes denied for the following services.

✓ Refraction	✓ ASC Facility Charges
✓ Post-Op Kits	✓ Lab Tests
✓ Ptosis (Cosmetic Eye Lid Surgery)	✓ Out of Network Referrals
✓ Copies of Medical Records	✓ Prescription Drugs
✓ Diagnostic Testing	✓ Pre-Existing Conditions

The undersigned and/or patient understand and agree to be personally and fully responsible for payment for all non-covered services as determined by your insurance plan.

MINOR PATIENTS

An adult accompanying a minor and/or the parents (or guardians of the minor) is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, VISA/MASTERCARD or payment by cash or check. We are not a party to any divorce decree or other legal judgements that outlay responsibility for medical payments.

USUAL and CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and our charges are usual and customary for our area.

INTEREST ON PAST DUE ACCOUNTS and COLLECTIONS POLICY

Interest will be charged on balances **unpaid 90 days from date of service** at a rate of 18 percent per annum (1.5% per month), and any account that is unpaid for a period of 180 days from date of service will be placed for collection. **Should collections become necessary**, the patient, or the patient's responsible party, will be responsible for all collection costs and attorney's fees therefrom.

Thank you for understanding our **Financial Policy**. Please let us know if you have any questions or concerns.

I have read the **Financial Policy** and I understand and agree to this **Financial Policy**.

Signature of Patient or Responsibility Party

Date