EYE CENTER OF SOUTHERN CONNECTICUT
A Medical and Surgical Group, P.C.

Financial Policy

Thank you for choosing Eye Center of Southern Connecticut as your vision care center! Our staff is committed to providing our patients with quality and affordable healthcare. Part of this care includes your responsibility as a patient to understand your financial obligations. *Please read and sign this financial policy, and return it to the receptionist with any questions you may have. A copy will be provided to you upon request.*

1. **Insurance.** We participate in most insurance plans. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Please note that providing a copy of your insurance card does not guarantee that your coverage is effective for the services rendered. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

    a. The Medicare deductible for 2020 is **$198**. You are responsible for this amount at the time of service if you do not have a secondary insurance, or your secondary does not cover this deductible. Please note that Medicare **REQUIRES** us to collect this portion of your deductible.

    b. If you are a Medicare patient with no secondary insurance, you will be responsible for your 20% co-insurance at the time of service.

    c. In the event it is determined that we need to send a specimen to a diagnostic laboratory, please be aware it is a separate fee that will be billed directly to your insurance company from that facility.

2. **Coverage 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. If your insurance company does not pay your claim in 45 days, the balance may be automatically billed to you.

3. **Co-payments and deductibles.** Please note that 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 what is due at each visit. A $10.00 processing fee will be added to any patients' accounts that do not pay at the time of service.

4. **Nonpayment.** Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit card,

debit cards, and pre-approved insurance for which we are contracted providers. However, if your account is over 90 days past due, you will receive a letter stating that you have 10 business days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be dismissed from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

5. **Missed appointments.** Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

    a. **No-Show Fee.** *$25* will be charged to any patient who does not show up for their appointment. The Eye Center reserves the right to dismiss a patient from the practice and deny him/her any future appointments after 3 no-show appointments.

    b. **Cancellation Fee.** $*25* will be charged to any patient who cancels an appointment without giving 24 hour notice.

We also understand that special, unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived at the discretion of the Eye Center.

6. **Outstanding Balance**. The Eye Center reserves the right to refuse a patient scheduled for a routine eye exam if they do not pay *at least 50%* of a prior outstanding balance either at the time of service, or on the phone when scheduling an appointment. Additionally, it will be mandatory that you store your credit card on file or we may refuse to see you.

7. **Credit Card on File.** At our discretion, we reserve the right to cancel your appointment or require you to pay at the time of service and keep a credit card on file if you:

    a. Do not present an insurance card.

    b. Do not have a referral, if one is required.

    c. Do not pay your co-pay, refraction fee of $55.00, or any other service deemed not covered by your insurance company.

    d. Are a new patient with a high deductible plan. If so, you will be required to store your credit card on file with us. *(Please note that all **established routine patients** will also be required to pay **$50** at the time of service upon check-in at the beginning of your plan year and/or if your plan deductible has not been met.)If you are a **surgery patient** with a high deductible plan, you will be required to pay **$300** prior to your surgery.*

EYE CENTER OF SOUTHERN CONNECTICUT
A Medical and Surgical Group, P.C.

_____

Patient/Responsible Party (PRINT)

_____ _____

Patient/Responsible Party (SIGNATURE) Date: