# Patient Financial Responsibilities

The Children and Family Eye Doctors, a division of Proliance Surgeons is committed to providing you with the highest quality medical care. Because patients are ultimately responsible for the charges associated with their care, even when insurance is in place, you may find the following information helpful. We realize you have choices for your medical care and appreciate your choosing The Children and Family Eye Doctors.

## Patient Responsibilities

You can help ensure an efficient experience by assisting with the following:

- Providing us with your picture identification, insurance card and Social Security number to enable us to submit your claims timely and accurately
- Knowing your insurance benefits and limitations
- Ensuring there is an authorization for our providers to treat you if it is required by your insurance, including obtaining a referral
- Providing us with copies of any pertinent medical records.
- Paying your estimated portion of the charges at the time of service
- Paying any additional amount owed when due
- Completing required incident/accident forms within 30 days of date of service
- Maintaining a current account with Proliance Surgeons at all times
- Providing us with at least 24 hours advance notice should you need to cancel or reschedule an appointment

Please note that co-payments, co-insurance and deductibles are a contractual agreement between you and your insurance carrier. We cannot change or negotiate these amounts.

## Insured Patients

We will bill your primary and secondary insurance carrier in a timely manner. If you are disputing payment with your insurance carrier or have a balance over $100.00 with us, you must notify our business office and make payment arrangements.

**Co-Pays/Deductibles/Co-Insurance** – Please be prepared to pay for your portion of the charges on the date of service. Office procedures (e.g., casting, scopes, tests, x-rays) will be billed separately from the office visit.

**Surgery** – If surgery is indicated, a pre-payment of both physician and facility fees is required for all elective, non-emergent procedures prior to the surgery being performed. Your out-of-pocket cost is estimated based on your benefits and our fees. Anesthesia and other providers are separate fees.

**Non-Participating Insurance** – If we do not participate in the insurance you have, we will file a claim as a courtesy. All unpaid claims will become your responsibility 45 days following filing and be immediately due and payable.

## Uninsured Patients

**Office Visits** – A $175.00 deposit is required prior to the appointment. If visits and services are paid in full at the time of service, we offer a 20% discount (see exclusions below). Office procedures (e.g., casting, scopes, tests, x-rays) will be billed separately from the office visit.

**Surgery** – For uninsured patients having surgery, we offer a 20% discount when charges are paid before or on the day of service (see exclusions below).

**Exclusions** – The discounts referenced above do not apply in cases of cosmetic procedures, motor vehicle accidents, third party insurance claims or in other cases when the patient may be reimbursed in full.

Private pay patients who receive retroactive Medicaid coverage need to immediately notify our business office.

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## Motor Vehicle Accidents (MVA) Insured and Third Party Patients

We do not extend discounts for MVA-insured accidents, third party insurance claims or in other cases when patients may be reimbursed in full. We will bill the MVA insurance carrier one time. The bill becomes your responsibility if not paid by the carrier in 30 days. We regret that we are not in a position to confer with attorneys or defer payment obligations while a case settles. If your personal injury protection benefit on your MVA policy is exhausted, we will bill your private insurance at your request provided we are furnished the necessary information at the date of service.

## Workers' Compensation

If your visit is work-related, we will need the case number and carrier name prior to your visit in order to bill the workers' compensation insurance carrier. If your workers' compensation claim is not yet accepted and you have no other insurance, we require a $175.00 deposit that will be refunded after the claim has been opened.

## Other Charges

**No Show** – Please provide us with at least 24 hours advance notice if you need to cancel or reschedule an appointment. We charge a $40.00 fee for missed appointments.

Please provide us with at least 48 hours advance notice if you need to cancel or reschedule an appointment and an interpreter has been scheduled. Otherwise, you may be charged for the interpreter.

**Forms** – There may be a charge associated with our completion of some forms. We require payment of the charge before returning the completed form to you. A signed Release of Information may also be necessary. Please allow five business days for us to complete forms.

## Payment

**Payment Options** – We accept cash, checks, major credit/debit cards and money orders for payment (no post-dated or third party checks). We charge a $40.00 NSF fee for any returned checks.

**Delinquent Accounts** – We charge a 5% interest accruing monthly on balances over 45 days old. We may assign an account to collections if balances are unpaid after 120 days. Patients assigned to collections may be denied additional service.

**Alternative Payment Arrangements** – If you are unable to pay your balance when due, please contact our business office to make alternative arrangements. Any patient with a past due amount may be denied additional service until the amount is paid or the patient is complying with an alternative payment arrangement.

**Bankruptcy/Prior Bad Debt** – Patients who have previously filed for bankruptcy or never satisfied their payment obligations for prior episodes of care with The Children and Family Eye Doctors or other Proliance Surgeons care centers may be required to pay for their portion of new charges at the time of service.

## Electronic Prescription Patient Consent

I agree that The Children and Family Eye Doctors may request and use my prescription medication history From other healthcare providers or third-party pharmacy benefit payers for treatment purposes

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Parent / Guarantor Signature Patient Name (Please Print)

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Date