

FINANCIAL POLICY

Refractions

Refraction is a **required** diagnostic test used by your physician to determine if you have or are borderline for one of the following:

- macular degeneration, a condition related to aging that affects your sharp central vision
- retinal vessel occlusion, a condition that causes the small blood vessels near the retina to be blocked
- retinitis pigmentosa, a rare genetic condition that damages the retina
- retinal detachment, when the retina detaches from the rest of the eye

Medical Insurance

We participate with most medical insurance plans including HMO's. If North Fulton Eye Center, PC & the Cumming Eye Clinic are not a participating providers in your insurance plan, patients will be responsible for filing their own claims and for payment in full at the time of service. Any part of your visit known to us that is not covered will be collected at time of service.

Medicare patients are responsible for any amount applied to your annual deductible. As a courtesy, we will file with your supplemental insurance. In the event you do not have additional insurance, you will be responsible for the total balance due.

Authorization & Referrals

Some managed care plans require us to have a valid authorization or referral at the time of service. If you plan is one such plan, please ask your PCP to request a referral from your insurance and forward it to our office. It is the patient's responsibility to facilitate this step with your PCP office and your ins. company. If your plan requires a referral and we do not have one on the day of your appointment your options will be to pay out of pocket or reschedule your appointment until a referral is sent to us. Please check with your PCP prior to your appointment with us.

Returned Checks & Past Due Accounts

Returned checks will be charged \$40.00 to cover bank fees. Patients with unpaid returned check fee will be required to pay this outstanding balance over the phone prior to making an appointment. .

Missed Appointments – "NO SHOW"

Please contact us **24 hours in advance** If you are not able to keep your scheduled appt. A date and time has been reserved especially for your visit with your doctor. Failure to keep your scheduled appointment will result in a **"NO SHOW"** charge of \$50. We will not be able to schedule additional appointments after (3) NO SHOW's. In the event that you have a special circumstance regarding your missed appointment, please contact our Practice Manager.

PATIENT ACKNOWLEDGEMENT

I have read all the information and understand that I am financially responsible for any/all diagnostic testing and treatment required by my physician to thoroughly diagnose and treat me today and going forward that is not covered by my insurance plan as long as I am a patient of this practice.

Patient Signature

Date

Contact Lens Wearers Only

If you wear contact lens, and want to renew your prescription, there is a \$40.00 charge in addition to any fees not covered by your insurance.

PARENTS/GUARDIANS OF MINOR

For an eye exam on younger patients, there may or may not be a medical diagnosis discovered in the course of the examination to code for your insurance. Oftentimes, the diagnosis for a healthy young person is solely refractive error (need for glasses), a diagnosis that some insurance companies equate with routine eye coverage. We will file with your insurance; however, we are not on any vision service plans. If your insurance does not cover routine eye care through your medical coverage, they may deny the exam, making you responsible for the total cost of the exam.

I understand that my child's visit may not be covered under the terms of my insurance and that I may be responsible for the total cost of the exam.

Patient / Guardian Signature

Date