



## FINANCIAL POLICY

Thank you for choosing Billings Retina & Macula for your eye care. We are committed to providing you with quality and affordable health care. Please read it and ask any questions you may have. You will be asked to sign a document stating that you have received this notice.

**Financial Responsibility:** We participate in most insurance plans, including Medicare. 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 do not have an up-to-date insurance card, payment in full for each visit is expected until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

You understand that you are financially responsible for all charges whether or not paid by insurance. Payment for medical care not covered under insurance is due at the time of service. We do not contract with all insurance carriers. It is your responsibility to check to see if we accept your insurance plan before services are provided to you. Many insurance plans require authorization before the time of the visit. Services performed without preauthorization are the responsibility of the patient.

**Proof of Insurance:** It is your responsibility to provide the office current insurance cards at the time of your appointment; and if you have more than one insurance plan, the order you would like your insurances billed for our services.

**Co-payments and Deductibles:** We require co-payments and deductibles paid at the time of service. This arrangement is part of your contract with your insurance company. We accept VISA, MasterCard, American Express, Discover, and debit cards. When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day we receive your payment, and you will not receive your check back from your financial institution.

**Patients 17 Years and Younger:** A parent or guardian must accompany the minor at the time of service and sign for services (exception: emancipated minors). The parent or guardian requesting services for the minor is responsible for all co-payments, deductibles or non-covered charges at the time of services.

**Medicare Lifetime Beneficiary Claim Authorization and Release of Information:** You request that payment of authorized medical benefits be made on your behalf to Eye Physicians & Surgeons PLLC d/b/a Billings Retina & Macula for any services furnished you by our office. You authorize Eye Physicians & Surgeons PLLC d/b/a Billings Retina & Macula and its agents and employees to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits or the benefits payable for related services. You understand your signature requests that payment be made, and you authorize release of medical information necessary to pay the claim. If other health coverage is indicated on the approved claim form or electronically submitted claim, your signature authorizes release of information to the insurer or determination of the Medicare carrier as the full charge; and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductible amounts are based upon the charge determination of the Medicare carrier.

**Commercial Insurance:** It is important for you to consult with your insurance company and our billing personnel prior to your visit to determine if our services are covered by your insurance carrier. If you belong to an HMO or Point of Service contract, you have an obligation to provide us with a referral number and to determine if our services are covered in your plan. Some or all services provided to you may not be covered as “reasonable and necessary.” The balance is your responsibility whether your insurance company pays or not. If your insurance company denies payment or has not paid your account in full within **45** days, the balance will automatically be transferred to you. Billed charges are due upon receipt.

**Assignment of Benefits:** You authorize any insurance or health plan carrier with whom you have a policy to pay any benefits of said policies directly to Eye Physicians & Surgeons PLLC d/b/a Billings Retina & Macula who has provided services to you and who accepts such assignment.

**Third Party Claims:** We will evaluate and/or treat a patient for an injury when legal action may be pending or contemplated. The fee for the evaluation or treatment is due and payable at the time the service is rendered and not following resolution of the legal case. We do not bill third party carriers.

**Workers Comp:** The State of Montana requires preauthorization for Workers Compensation claims. Claims not preauthorized are the responsibility of the patient.

**Delinquent Accounts:** In the event that you default on payment of your account, you agree to be responsible for collection fees and interest due on amounts in default, including court costs and reasonable attorney’s fees. If the debt is assigned to a third party for collection, you agree to be responsible for collection fees and interest due on amounts in default.

If you have any questions regarding our financial policy, please feel free to discuss them with the manager. Changes to the Terms of This Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

You will be asked to sign at check-in that you have received a copy of this disclosure, or you know that you can obtain and see a copy of this disclosure on our website.