The Eye Associates

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FINANCIAL POLICY

Thank you for selecting our office for your eye care. In order to prevent any misunderstanding concerning the responsibility for payment for medical and surgical care, the following is necessary for you to read and understand prior to your being seen by our physician.

Medical/Vision Coverage

Our practice takes most medical insurance plans and various vision plans. An exam with our practice may present either a medical diagnosis or vision diagnosis. Since we are unable to determine what the outcome of the exam may be, we ask that the patient has, if at all possible, both medical and vision insurance to ensure coverage regardless of diagnosis. In the event that the patient does not have both types of coverage, and the exam has a diagnosis that isn't covered by the insurance, the patient is then responsible for the full amount. **It is the patient's responsibility to know their benefits and coverage prior to the exam.**

Insurance Coverage

If you have a health plan that we do not have a contracting agreement with, we will submit the claim on an unassigned basis. In this case our charges for your care will be due at the time of service.
We will submit a claim to those plans we have a contractual agreement with and will require the patient to pay the authorized co-payment and co-insurance at time of service.
It is the patient's responsibility to know their benefits and coverage prior to the exam.

Medicare

Our physicians participate in the Federal Medicare program. Medicare will pay 80% of the approved charges after the paid annual deductible. As the patient, you will be responsible for your 20% coinsurance. If there is a secondary insurance, we will submit directly to that company after receipt of Medicare's allowable.

Refractions/Prescription for Glasses

Refraction (the determination of a prescription for glasses) is not a covered service under Medicare and many other insurance companies. As a courtesy, we will submit this charge to your insurance company. If you, the patient, have chosen to have this test performed, upon signature you are agreeing to pay the usual and customary charge for the service if the insurance company determines this is not a covered service.

Assignment of Benefits

I, the patient, request that payment of authorized Medicare/ Medicaid/ Private Insurance Company benefits be made on my behalf to The Eye Associates for services furnished to me by the provider. I authorize my provider or his/her designee to release to CMS, Idaho Medicaid program or any insurance program or company through which I am entitled to benefit coverage or agent thereof any information needed to determine benefits or the benefits payable for related services.

I HAVE READ THE ABOVE AND AGREE THAT I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ALL SERVICES.

_____	_____	_____
Signature of Patient or Responsible Party	*Print Name*	*Date*