Bloomfield Eye Associates Financial Policy

We are committed to providing you with the highest level of service and quality care. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. To achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, all financial liability rests with the patient. We take no responsibility for any services and/or medication costs denied by your medical insurance carrier.

Our office participates with most major insurance plans. We provide **medical and surgical** ophthalmologic care to our patients. **If you have a managed care plan that requires a referral to see a specialist, you must obtain a referral for your evaluation in our office prior to your examination. Otherwise, your examination, testing, and treatment will not be covered by your medical insurance carrier.** If you do not have a valid referral and still wish to be seen, you will be asked to pay for your visit prior to your examination.

A refractive examination is not a covered service under most insurance policies (including Medicare). If you receive a prescription for glasses, you will be charged $40, payable at the time of your visit. Any payments by check that do not clear with your financial institution will be subject to a $20.00 returned check fee.

It is the patient's/parent's/guardian's responsibility to:

- Be familiar with the benefits of your plan, including co-pays, co-insurance and deductibles.
- Bring all of your current insurance cards and valid ID to all visits.
- Provide our office with current information including address, phone numbers and employer.
- In accordance with your insurance contract, you must be prepared to pay your co-pay at the time of each visit.
- We accept cash, checks, and all major credit cards for services.

We appreciate prompt payment in full for any outstanding balance. If your account is turned over to a collection agency, you hereby agree to pay a **35%** finance fee (imposed by the collection agency) to collect the overdue balance on your account.

I have read and understand the above financial policy.

_____ _____

Signature of patient/guardian/parent Date

_____ _____

Printed name of patient Date