CHESTERFIELD OPHTHALMOLOGY FINANCIAL POLICY

INFORMATION AND BENEFIT AUTHORIZATION

Our practice is a provider for most major medical insurance plans, and we will file **one claim per covered service** to any plan for which we are actively participating. Please be aware if you provide us with an insurance card that is not current or accurate and the claim is denied, the charges will become your full responsibility. You may try to re-file the claim yourself for possible reimbursement, but prompt payment of your account balance with us will be expected upon receipt of your initial billing statement. If a claim is successfully filed and processed, you will still be financially responsible for any applicable co-pays, deductibles, and non-covered services. If you do not have insurance or we are not providers for your plan, full payment for all charges will be collected at the time of service.

ADDITONAL REMINDERS.

Although we are happy to provide assistance in resolving any billing questions or concerns, it is ultimately your responsibility to understand your specific insurance benefits and coverage rules. If your plan requires a specialist referral, you will need to obtain one from your primary care physician prior to being seen or a signed payment waiver will be requested before services are rendered.

In addition to the refraction services, patients who wear contact lenses (new or current) incur an *additional* non-covered charge for applicable fitting and evaluation services necessary for initiating or continuing the successful, healthy wear of contact lenses and generating or renewing a contact lens prescription. Annual exams will be required, and all contact lens prescriptions dispensed will reflect a one-year expiration date from the last full examination performed.

We are not providers for most vision plans, so you will be responsible for certain services that your medical insurance plan defines as "routine vision" and therefore not covered, i.e. the refraction and contact lens assessment. All other charges for evaluations or diagnostic testing that carry a justified medical condition or active symptom diagnosis will be filed under your major medical coverage. In some case, it may be beneficial for ***you*** to file the refraction and any other applicable non-covered charges directly to the vision plan for possible reimbursement of at least some of your out-of-pocket expense. We will gladly provide an additional itemized receipt for this purpose upon request.

As a courtesy, we attempt to call and remind you of your appointment one to three days prior to your visit. Please be aware that we charge a $25 fee for any appointments not kept without a formal 24-hour notice of cancellation.

I have read and understand the financial policy of Chesterfield Ophthalmology as stated above. All of my questions concerning this have been answered to my satisfaction.

I hereby authorize Chesterfield Ophthalmology, P.C. to release the information requested to the insurance company designated in my registration information. I hereby assign payment directly to Dr. Stephen M. Busch of benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. In the event that I fail to meet my financial obligations, I agree to pay attorney and/or collection agency fees in the amount of 30% of the total account balance at the time the account is turned over for collection, plus court costs and any additional collection fees. A late fee of $3 will be charged to each account at the 60-day, 90-day, and attorney notification letter delinquency mark.

Patient or Guarantor Signature _____ Date _____