FINANCIAL POLICY/INSURANCE SUBMISSIONS

Payment in full is required at the time of service for all non-insured patients and insured patients with past due balances, deductible amounts that have not been met, and any other coverage that could not be verified at the time of service. As the patient, you are required to pay the co-pay/coinsurance at the time of service. Claims are billed to the insurance carrier as a courtesy; however, you are responsible for payment of all charges incurred. Please be advised that there are some clinical and surgical procedures that your insurance will not cover. Therefore, by signing this document, you agree to be held financially responsible for services rendered on or before the time of surgical or clinical service. All balances not paid by the insurance carrier within 90 days of the date of service will be your responsibility. We will be happy to refund you for any payments made by you after your insurance company has paid in full for covered services.

_____ **INITIAL** – I have read and agree to the above statement.

Insurance Changes

If there are any changes to your insurance information, please notify our office immediately. Woolfson Eye Institute/Woolfson Ambulatory Surgery Center will not be responsible for timely filing if we do not receive the correct insurance information prior to or at the time of the visit. It is mandatory to notify your provider of any other insurance carrier who is responsible for payment.

_____ **INITIAL** – I have read and agree to the above statement.

Returned Checks

All checks returned for insufficient funds, closed accounts or for any other reason will be subject to a $25.00 service charge. All further payments must be made either by credit card, money order or cash.

_____ **INITIAL** – I have read and agree to the above statement.

Deductibles/Coinsurance/Co-payments

Deductibles, coinsurance and co-payments will be collected at the time services are rendered. These are required by your insurance company and agreed upon by you when you accept their insurance. We also must contract with insurance companies, agreeing to collect co-payments, coinsurance and deductibles, in order to participate with their plans.

_____ **INITIAL** – I have read and agree to the above statement.

Collection Policy

Once a charge becomes a patient's responsibility, any balance not paid after 90 days will be turned over to an outside collection agency. Balances will also be turned over to patient responsibility if insurance is unable to process claims due to missing or incomplete information not provided by policy holder to their insurance company. Any account turned over to collections will be assessed a collection fee of 30 percent of the total amount due.

_____ **INITIAL** – I have read and agree to the above statement.

Social Security Number

Our office policy requires your social security number to be provided for billing and insurance purposes. By declining to provide us with a social security number, you agree to pay for your services prior to services being rendered.

_____ **INITIAL** – I have read and agree to the above statement.

Surgical Predetermination Process

Predetermination takes place prior to surgery and requires that a letter of medical necessity, any photographs and/or testing be sent to your insurance company for review and possible approval. This process can take four to six weeks, and if surgery is approved, there is no guarantee of payment. *Should you wish to proceed with an unapproved surgical procedure, you will be asked to sign the waiver in lieu of insurance claim filing, and we will ask for payment in full. Woolfson Eye Institute will not refund any private pay monies collected on an unapproved surgery. You may wish to file the claim on your own and agree to accept what your insurance company PAYS YOU after the surgery has taken place.*

_____ **INITIAL** – I have read and agree to the above statement.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. We would be willing to discuss reasonable payment plans. If you have any question about the above information, please do not hesitate to ask us.

I hereby assign all medical and/or surgical benefits, to include major medical benefits that I am entitled, including Medicare, private insurance and any other health plan to Woolfson Eye Institute/Woolfson Ambulatory Surgery Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, whether or not these charges are paid by my medical insurance. I hereby authorize Woolfson Eye Institute/Woolfson Ambulatory Surgery Center to release any and all information necessary to secure payment.

Name (PRINT): _____ Date: _____

Signature: _____

Witness (staff member): _____