

Hattiesburg Eye Clinic, P.A.

FINANCIAL POLICY

- **Payment Due:** I understand that payment is due when service is rendered. If for some reason I am not able to pay at the time of service, my appointment may be rescheduled.
- **Co-pays, Co-insurance and Deductibles:** It is my responsibility to know what my co-pay, co-insurance and deductibles are, and my obligation to pay this at the time of service.
- **Insurance Coverage:** I acknowledge that the insurance cards I have presented are current and accurate.
- **Non-covered Services:** I understand that some services may be considered non-covered services by my insurance plan. I understand that it is my responsibility to know what my insurance does or does not cover, and I understand that I am financially responsible for paying all non-covered services.
- **Denied Charges:** I understand that some charges may be denied by my insurance carrier as investigational, experimental or not medically necessary and will not be paid by my insurance carrier. I understand that my physician feels these services are needed whether my insurance carriers deems them payable or not and that I am obligated to pay for these services in full.
- **Refractions:** Refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary in order to write a prescription for glasses or contact lenses. Medicare and most medical insurances do not cover the fee for refractions. I understand that I am responsible for this \$20.00 fee and it is payable at the time of service.
- **Participating Insurance Plans:** If HEC is not a participating provider in my insurance plan, I will be responsible for filing my own claims and I will be responsible for paying in full at the time of service.
- **Returned Checks & Past Due Accounts:** Return checks will be subject to a \$30.00 fee. All accounts are considered past due if not paid within 90 days of service. Past due accounts may result in being turned over to an outside collection agency and subject to penalties and interest, or the refusal of future appointments until old balances have been paid in full.
- **Tricare:** Some Tricare plans require prior authorization/referral for medically necessary visits. I understand that it is my responsibility to obtain this authorization/referral before my appointment from my primary care manager.
- **Medicaid:** I understand that if Medicaid is my secondary coverage and that if my primary insurance has co-pay, I will be responsible for paying my co-pay amount associated with my primary insurance plan. HEC will not file a claim with Medicaid because Medicaid does not cover co-pays. If I have exceeded my yearly allotted visits with Medicaid, I will be responsible for paying for my visit in full at the time of service. If Medicaid is my only carrier, I am responsible for paying the Medicaid co-pay amount at the time of service.
- **CHIPS (Children's Health Plan):** I understand that HEC participates in the CHIP program for medical conditions only. HEC Physicians do not participate in CHIPS vision plan. If no medical diagnosis is found, even if you were referred by another physician, you will be responsible for all charges.
- **Vision Plans:** HEC participates in a very limited number of vision plans. Please inform us before your exam if you are filing for a routine vision exam.

I have read the HEC Financial Policy and understand, that I, the patient or the patient's representative, am/is responsible for payment of all charges for service rendered. I also acknowledge that non-payment of my account may result in collections proceedings and dismissal from the practice.

Date: _____ **Signature of the Patient or Representative**

I authorize the release of any medical information necessary to process all claims and I authorize the release of payment for medical benefits to Hattiesburg Eye Clinic, P.A.

Date: _____ **Signature of the Patient or Representative**