East Michigan Eye Center Patient Financial Policy

Thank you for choosing our practice as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

Co-pays and Deductibles
All co-payments, deductibles and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted.

Insurance Claims
Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company does not pay for any of your services performed at our office, you may be responsible for the complete balance of the non-payable services. If we are out of network with your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Workers' Compensation and Automobile Accidents
In the case of a workers' compensation injury or automobile accident, you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier prior to your visit. If this information is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service.

Missed Appointments
We require 24-hour notice of appointment cancellation. Appointments missed and are not previously canceled may be charged a fee of $25.00.

Refractive Fee
The determination of the refractive state of your eyes is rarely covered by

medical insurance and never covered by Medicare. If your insurance does not provide coverage for this service, you will be asked to pay $35.00 for the service when it is provided.

 Initials_____

Returned Checks

The charge for a returned check is $25 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Minors

The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors. The parent (s) or guardian(s) must stay with minor thorough out exam.

Outstanding Balance Policy

It is our office policy that all past due accounts be sent 2 statements. If payment is not made on this account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

I, _____ have read the above financial policy and understand my financial responsibility to my healthcare provider.

_____

Patient Signature Date

_____

Witness Date