ASHLAND EYECARE

FINANCIAL POLICY

1. **BILLING**: We need to know your current insurance carrier(s) so that we can meet their deadlines for billing of our services. If you have changed insurance and not informed us, we will bill the last plan in your records. When they deny the claim, we will bill you directly for payment, and you must seek reimbursement from your current insurance. For this reason, it is important for you to present your current insurance card at the time of your appointment at least once a year.

2. **CO-PAYS/COINSURANCE/DEDUCTIBLES: All co-pays are due at the time of service.** Please refer to your insurance card or benefit handbook for your plan requirements. Please be prepared to pay at the time of services or your appointment may be rescheduled. **MINORS:** The adult presenting with a child for treatment is responsible for payment of the patient portion at the time of service.

3. **INSURANCE BILLING:** The services provided to you by Ashland Eyecare, Inc. are directly to you and/ or your dependent therefore, you are responsible for the payment of services. We cannot render services on the assumption that all charges will be paid by your insurance company. As a courtesy, our office will bill your primary and secondary medical insurance company and/or in network vision insurance when applicable, for all charges for services rendered. However, if your insurance company fails to pay within 45 days of submission we will bill you for reimbursement.

4. **MEDICAID/BCMH:** For patients on traditional Medicaid the office policy requires a copy of your current Medicaid card at each visit. For BCMH we will need your Letter of Approval (LOA) each time you are seen in our office. If the patient does not have their current Medicaid Card or BCMH (LOA) their appointment will be rescheduled. All Medicaid and BCMH patients are required to provide their current health coverage information to the receptionist for update at each visit.

5. **SELF-PAY:** For those who do not have insurance we expect payment on the day of your visit. We accept Visa, Mastercard, American Express and Discover as well as cash, debit cards and checks for your convenience.

6. **RETURNED CHECK POLICY:** there is a $50.00 charge for checks returned for non-sufficient funds.

Informing our patients about our financial policy assists us in providing the best financial service to them. I understand that providing current insurance information and being prepared to pay my copay will avoid extra and inconvenient costs. I understand that not complying with the guidelines ultimately **requires me to pay in full** for the services rendered at time of service or receipt of the first statement.

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Signature of Patient/Parent/Guardian Date

_____ _____

Printed Name Account #

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Email