



# **FINANCIAL POLICY**

## **EYE CARE SURGERY CENTER FINANCIAL POLICY**

(Please Read Carefully and Sign)

Fees for medical services are to be paid at the time of your visit. Payment may be in the form of cash, personal check or major credit card. This policy has, unfortunately, been necessitated by the high cost of billing, problems with collections, and a sincere attempt to keep the cost of medical services down.

### **PERSONAL HEALTH INSURANCE**

You are expected to pay the co-payment, deductible, and/or co-insurance upon each visit to our office. To assist you in getting the maximum reimbursement from your insurance company, we will file all health insurance claims for you. On any services rendered that are not covered by your insurance company, the non-covered portion is to be paid at the time of service. (Example: if BlueCross BlueShield pays 80% of a \$50.00 fee, then you are expected to pay the \$10.00 which is the 20% not paid by your insurance.)

### **COMMERCIAL INSURANCE - MCO/PPO/HMO**

All patients are expected to make their co-payments at the time services are rendered. On any services provided that are not covered by your insurance plan, you are responsible to pay the amount of the non-covered service.

### **WORKERS' COMPENSATION**

If the reason you have come to our office is the result of a work related injury, we will assist you in getting the Workers' Compensation Claim verified for the payment of all your medical bills for services provided by our office. We will only be able to do this with adequate information from you about the exact time, location, and nature of your injury. In order for us to properly handle any Workers' Compensation Claims, please have this information available and notify the receptionist as soon as you report to the office. If Workers' Compensation coverage cannot be verified prior to treatment, the responsibility for payment of the services is yours, the patient.

### **MEDICARE**

Eye Care Surgery Center is a participating provider with Medicare and therefore accepts what Medicare allows as the amount due for the services rendered. Because Medicare only pays eighty percent (80%) of the amount allowed, it is your responsibility to pay the twenty percent (20%) co-insurance (Patient Portion) or any deductible that has not been met. We will file the insurance claim for you to assist you in getting the maximum reimbursement from Medicare. On any supplies or services that are not covered by Medicare, the responsibility for payment will be yours.

### **MEDICAID**

Eye Care Surgery Center is a participating provider with Medicaid and therefore accepts what Medicaid pays as the amount due for the services rendered. On any supplies or services that are not covered by Medicaid, the responsibility for payment will be yours.

### **LEGAL CASES**

If the reason you have come to our office is as a result of an attorney sending you for medical evaluation or treatment, payment at the time of the appointment is required prior to services being rendered. Due to the ongoing nature of caring for patients involved in legal cases, it will be necessary for the attorney to pay for the services each time you come for treatment unless special payment arrangements have been made with your attorney. Regardless of the payment arrangement terms, it is our policy that your attorney provide us a letter of

guarantee for payment along with the execution, by you and your attorney, of a "Medical Lien" agreement for the services provided. Full payment of medical fees billed, without discount or adjustment, is expected on all legal cases, regardless of payments by a third party insurance company or managed care organization.

**TO ASSIST US IN PROVIDING YOU WITH THE BEST SERVICES POSSIBLE, PLEASE VERIFY THAT WE HAVE ALL CURRENT AND CORRECT INFORMATION FOR YOU ON EACH VISIT TO OUR OFFICE. THIS INFORMATION INCLUDES YOUR NAME, ADDRESS, PRIMARY TELEPHONE NUMBER, ALTERNATE TELEPHONE NUMBER, AND INFORMATION RELATING TO ANY INSURANCE COVERAGE YOU MAY HAVE.**

Unless special arrangements have been made, any patient with an unpaid balance over (60) days old will only be seen if the balance is paid in full prior to treatment.

In the event that we find it necessary to pursue legal action to collect your account, all collection expenses, attorney fees, and court costs will be added to the balance.

A fee of Twenty-Five Dollars (\$25.00) will be assessed on any "NSF" checks.

I fully understand that I am directly and totally responsible for all medical bills submitted for the services rendered to me as a result of my illness or injury.

**\*\*\*\*PLEASE NOTE\*\*\*\***

**Medicare, Medicaid, and most other insurance companies WILL NOT pay for REFRACTIONS (testing for glasses) or Routine Eye Exams (exams for blurred vision, headaches, or yearly exams not related to a medical disease).**

**The fee for Refractions (testing done to give prescriptions for glasses) is \$25.00. This fee PLUS any co-payment or deductible is DUE AT THE TIME OF SERVICE.**

**PATIENT/GUARANTOR ACKNOWLEDGEMENT AND ACCEPTANCE**

I have read and understand the terms of the "Financial Policy" of Eye Care Surgery Center, and agree to abide by the terms and conditions stated therein.

\_\_\_\_\_  
Patient/Guarantor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Printed Name)

\_\_\_\_\_  
Eye Care Surgery Center, Representative

\_\_\_\_\_  
Date

Federal and State law requires your physician to disclose to you any ownership or financial interest your physician may have in any entity or other health care provider you are referred to for additional services. If you have a question about your physician's relationship with any entity or other health care provider you are referred to, please ask.

**LOCATIONS**

There are four Eye Care Surgery Center locations to serve you.

**Baton Rouge  
Gonzales**

**Hammond  
Covington**