



# Montgomery Eye

## Financial and Payment Policy

We are concerned about the cost of your health care and want to address some current issues related to the cost of medical services. Please take a moment to review this information.

Considerable care has been taken in setting our fees. Every effort has been made to ensure that our charges accurately reflect the complexity of care rendered and the skill and expertise required for your care.

**Please understand that our service agreement is with YOU and NOT your insurance company.** Just as you have chosen your insurance coverage, you are ultimately responsible for payment of the service you receive. Any claims filed by us are done as a courtesy. If no payment is received from the insurance company within 45 days, payment will be due from you. If, after you have contacted your insurance company, further assistance is required from our office, we will be glad to help. We thank you for your cooperation in this matter.

### **MEDICARE:**

We are Participating Providers and accept the Medicare approved amount as the total charge for Medicare covered patients. However, please remember that Medicare alone does not cover the full-approved amount. The 20% co-payment, the deductible, and any necessary charges for non-covered services remain your responsibility. If you have Medigap (Medicare supplement) insurance to help with these charges, it will be filed with your Medicare.

### **HMO OR PPO MEMBERS:**

If you are a member of an HMO or PPO in which we participate, your deductible or co-payment, if any, is required at time of service. You are also responsible to ensure that we have a current referral if your insurance carrier requires one. In the event that a referral is required but not obtained, you will be responsible for the payment of services in full.

### **OTHER (COMMERCIAL) INSURANCE:**

Payment at the time of service is required for all office charges under \$100. To assist you in seeking reimbursement from your insurance company, we will provide you with an itemized statement containing all the information necessary to expedite your claim.

### **CHARGE CARDS:**

For your convenience, we are pleased to accept Visa<sup>®</sup>, MasterCard<sup>®</sup>, and Discover<sup>®</sup> for your charges.

### **RETURNED CHECKS AND DELINQUENT ACCOUNTS:**

Non-sufficient funds checks are collected through Nexcheck<sup>®</sup> and are subject to all fees associated with payment recovery. In the event that your account becomes delinquent and must be placed with a collection agency, you will be responsible for all costs of collection. Timely payment will prevent consequences to your credit rating.

### **BILLING FEE:**

There will be a \$10 billing fee for co-payments and refractions that are not paid at time of service.

***I have read and understand my financial responsibilities under this policy.***

\_\_\_\_\_  
Signature of Patient/Responsible Party

\_\_\_\_\_  
Date

***If you have questions about our financial policy or your insurance reimbursement, please discuss them with our staff.***