ROUSE EyeCARE CENTER

Payment & Financial Policy

Thank you for choosing us as your eye care provider. We are committed to providing you with highly competent, conscientious, quality eye care. This policy is intended to provide information regarding patient and insurance responsibility for services rendered. Please read it - initial and date pages #1 & #2 and complete the final page #3 with your signature, printed name, and today's date in the spaces provided. Please ask any questions or concerns you may have. A copy will be provided to you upon request.

1. **Insurance.** We participate in a number of insurance plans. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card or insurance plan, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-Payments, Cost Shares, Coinsurance and Deductibles.** All co-payments must be paid at the time of service. Any cost share, coinsurance and/or deductible amount is due and payable once your claim has been adjudicated. This arrangement and requirement is part of your contract with your insurance company, and cannot be billed to you at a later date. All co-payments not paid at the time of service are subject to a $7.00 administrative fee payable to ROUSE EyeCARE CENTER which is not covered by your insurance. Failure on our part to collect co-payments, cost shares, coinsurance and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Insurance Referrals and/or Preauthorization.** If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a reduced payment from your insurance company. You agree to pay any portion not covered by insurance.

4. **Non-Covered Services.** Please be aware that some and perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by your insurance carrier. You must pay for these services in full at the time of service. Reimbursement is subject to the terms of your insurance contract.

5. **Proof of Insurance & Identity.** All patients must complete our patient registration, information and policy forms before seeing the doctor. We must obtain a copy of your valid Driver's license and valid insurance card(s) to provide proof of insurance and your identity. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of the claim.

6. **Claims Submission.** We will submit your primary insurance claim and assist you in any way we reasonably can to help get your claim paid. Any secondary, supplemental and/or multiple primary insurance claims submissions by us are subject to a $10.00 administrative fee payable to ROUSE EyeCARE CENTER which is not covered by your insurance. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are NOT party to that contract.

7. **"Routine" Vision Benefit.** There has been discussion and confusion about the "Routine" benefits offered by insurance plans and how it applies to your visit. Your "routine" vision benefit provides for an eye exam to check your vision; as it applies to nearsighted, farsighted or regular astigmatism and if you require eyeglasses or a change in your current eyeglasses. "Routine" vision benefits are not intended as a medical exam to diagnose or treat eye disease or pathology. If you are diagnosed with any eye pathology, such as, but not limited to: cataracts, glaucoma, macular degeneration, dry eye, or a binocular vision disorder, these types of conditions are covered under your health insurance plan and the doctor will bill your exam accordingly. If we uncover a medical condition, the examining physician will be billing your health insurance carrier because the "routine" vision benefit does not cover the testing or procedures necessary to appropriately assess and outline a plan of treatment for any eye disease or condition. We can only file your "Routine" Vision Benefit, such as, a VSP claim if we are notified that you are an active VSP Member prior to your exam. There will be a $40.00 administrative fee payable to ROUSE EyeCARE CENTER in order for us to file your exam or optical VSP claim retroactively which is not covered by any insurance.

Please... Initial:_____ **Date:**____/____/____

8. **Refraction.** The Refraction is a procedure whereby an individual's "error of refraction" of each eye is determined, thus indicating a potential need for compensatory visual aids such as; but not limited to, eyeglasses. Please be aware and informed that you may be refracted as part of your eye examination, and most insurance plans, including Medicare and TRICARE for Life, do not cover this separate and identifiable ophthalmological procedure. You may know the Refraction test as a procedure for determining the need or lack thereof for eyeglasses. Incidentally, vision loss can be gradual and not readily perceived by the patient leading to permanent damage. Therefore - the Refraction is an essential test for a proper and thorough diagnosis of the human eye, and detecting certain types of vision loss. A Refraction may be straightforward (CPT 92015) costing $50.00 or complex (CPT 92015-22) costing $75.00 payable to ROUSE EyeCARE CENTER on the date of service.

9. **Provided Services and Charges.** The Office of the Inspector General (OIG) has deemed that not charging for a provided service is an *"inducement"* to the patient and therefore illegal. As a result, the Federal Government insists that if an exam, procedure or test is performed, it must be charged accordingly. The concern and worry is that some physicians may attempt to lure patients to their respective practice by offering a reduction in fees as an incentive, and thereby creating a conflict of interest in the patient-doctor relationship and potentially altering the patient's cognitive ability to choose a provider on the merits of the care and physician's qualifications. Furthermore, such inducements would create a biased provider network. As providers, we have an affirmative obligation to charge for all of our services accordingly.

10. **Coverage Changes.** If your insurance changes or you add insurance, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 30 days from the date of submission, the balance will automatically be billed to you.

11. **Nonpayment Fees.** If your account is 30 days past due, you will be charged $15.00 if the balance is less than $100.00; $29.00 if the balance is $100.00 or more, but less than $250.00; and $39.00 if the balance is $250.00 or more. The outstanding balance due will continue to accrue nonpayment fees every 30 days past due and shall be calculated by taking the balance owed 30 days ago, and then subtracting any payments applied to the account during that time. Please be aware that if the balance remains unpaid, we may refer your account to a collection agency. In addition to the amount owed, you will be responsible for the fee charged by the collection agency and costs of collections (as applicable by state law). Returned payment fee is assessed at $39.00.

12. **Payments and Due Date.** The total balance of your statement is due and payable to ROUSE EyeCARE CENTER when the statement is issued, and is deemed past due if payment in full has not been received in our office by the stamped statement due date (30 days from the statement mail-out date).

13. **Monthly Statement.** If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, nonpayment fees, if any, and any payments applied to your account during the month.

14. **Missed Appointments, No-Show or Late Cancellation-Reschedule.** Our policy is to charge $50.00 for missed appointments, no-shows, late cancellations-reschedules. If you are unable to keep your appointment, please notify ROUSE EyeCARE CENTER 24 hours prior to your appointment. These charges will be your responsibility and billed directly to you. Please help us to serve you better and other patients by keeping your regularly scheduled appointments.

15. **Waiver of Confidentiality.** You understand if your account is submitted to an attorney or collection agency, if litigation ensues, or if your past due status is reported to a credit reporting agency, the fact that you received care at ROUSE EyeCARE CENTER may become public record.

16. **Credit History.** You give ROUSE EyeCARE CENTER permission to investigate your credit and employment history and to answer questions about your credit experience with our practice. We have the option to report your account status to any credit reporting agency such as a credit bureau.

17. **Divorce.** In case of divorce separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a minor will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment or product costs, it is the authorizing parent's responsibility to collect from the other parent.

18. **Transferring-Copying of Records.** If you would like a copy of your health records, please provide us with your request in writing. We charge a reasonable and customary fee, as permitted by WAC 246-08-400, to duplicate and assemble your copy.

Please... Initial:_____ **Date:**____/____/____

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19. **Workers Compensation.** We require written approval and/or authorization by your employer and/or worker's compensation carrier prior to your initial exam. In your claim is denied, you will be responsible for payment in full.

20. **Personal Injury.** If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial exam. In addition to this verification, we require that you allow ROUSE EyeCARE CENTER to bill your health insurance. In the absence of insurance, other arrangements may be discussed. Payment of the bill remains the patient's responsibility. ROUSE EyeCARE CENTER cannot bill your attorney for charges incurred due to a personal injury case.

21. **Co-Signature.** If this or another Payment & Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

22. **Forms and Reports.** Our office will complete DMV, school, military, benefit or work documents at no charge, as it only relates to our treatment or services on the same day of service. A charge of $15 will be assessed for completing the aforementioned forms or reports after the date of service.

23. **After Hours Care.** If you should require eye care after our scheduled hours, please understand that there is an additional fee not covered by your insurance. This fee of $55.00 will be billed directly to you. All examination and testing pertaining to the after-hours care will be billed to your medical insurance, if any.

24. **Finalized Claim.** The cost for a particular date of service is not complete until the finished documentation for that visit is reviewed for accuracy. Any price quoted to you, before your visit or at the completion of your visit, is an estimate. The complete billing may differ from that estimate.

25. **Optical Lab.** We use a large spectacle lens lab which enables us to offer the highest-quality lens materials, use lens designs more customized to the individual patient's needs and use precise, computerized production technologies, which are not practical in small labs; such as a one hour optical store. Consequently, your eyewear order delivery date can vary depending on the complexity of your prescription. We will always strive to provide you with a realistic and explicit delivery date for your eyewear, and to inform you of the actual delivery date if different than what was promised.

26. **Eyewear.** Our service does not end when you pick up your new eyewear. We will gladly adjust your eyewear or answer any questions at any time. We stand behind all of our products. Our frames are warranted for one year from the date of purchase against manufacturer defects that are covered by the manufacturer's warranty. We honor all lens manufacturers' warranties which cover manufacturing defects, but not damage induced by the wearer, such as abuse from rough handling or incorrect cleaning. Cancelled eyewear (spectacles, sunglasses, low vision aids) and contact lenses will incur a 20% cancellation fee of the total retail price; and only, if we are able to cancel your order through our optical lab or applicable vendor. Please be aware that after an optical order has reached a certain stage in manufacturing, we may not be able to cancel your optical order without you incurring the total retail cost. The timeliness of any optical order varies and is driven by such complexities as the frame, lenses, coatings, tints and of course the prescription. We work hard to ensure you receive the highest quality eyewear products and we will always strive to exceed your needs, wants and expectations.

Our practice is committed to providing the best treatment and service to our patients. Our prices are representative of the quality and effectiveness of the care being provided. Thank you for understanding our payment and financial policy. Please let us know if you have any questions or concerns.

I have read and understand the payment and financial policy and agree to abide by its guidelines:

X _____

Signature of Patient or Responsible Party

X _____

Printed Name **Date**