Coastal VisionCare FINANCIAL POLICY and HIPAA ACKNOWLEDGEMENT:

*Patient refers to patient or guarantor

When making an appointment at Coastal VisionCare a time has been reserved for your care, therefore a patient or dependent agrees to be held by our financial policy. If any questions remain, please call our office at (321) 724-2020 for clarification.

Patients or their guarantor are responsible for timely payment of services or products ordered through our office. Upon request, we will provide an estimate of cost of specific services or cost of products. However, it is not possible to give exact charges for certain services until the doctor has seen the patient.

NO SHOW POLICY: *The time of your appointment has been reserved for you and the Doctor is setting aside time for your care.* Therefore, any patient who does not give 24 hours' notice of a cancellation or does not show for a same day appointment will be charged a $40 fee. Your insurance company will not cover this fee and the charge will need to be paid before services will be rendered. We attempt to call patients as a reminder of an appointment; however, this is a courtesy we provide and has no effect on the no show policy.

_____Please Initial you understand the No Show Policy

PAYMENT: Payment is expected at time of service. We accept cash, check, Visa, Mastercard. Discover and Care Credit.

If you are later billed for charges not covered by your insurance company, payment is expected upon receipt of the bill. If payment is not received after 2 billing cycles, you will be charged $15.00. If payment is not received after 3 billing cycles, you will be turned over to our collection agency.

CONTRACTED MANAGED CARE: We are happy to work with your insurance company. However, it is your responsibility to bring your vision and medical insurance card to every visit. If you fail to bring your insurance card, you will need to pay for charges in full and then submit your receipt to your insurance company.

As a courtesy we attempt to call your insurance company and check on patient benefits. However, it is your responsibility to understand your insurance benefits. As per instructions from insurance companies, your insurance company does not guarantee payment for services until we have billed them. Therefore, a patient is responsible for any overages not covered by your insurance company.

We file to primary insurances only. If you have a secondary insurance that is not linked to your primary insurance, you will be required to pay us and submit your receipts to your secondary insurance.

COPAY: As required by your contract with your insurance company, a copayment is a portion of the fees a patient or dependent is required to pay. A copayment is required to be paid at the time of service.

NON-COVERED SERVICES: Fees not covered by your insurance company will require payment at time of service.

NON-CONTRACTED MANAGED CARE: We have not contracted with certain managed care plans and we are not contractually obligated to accept the payment made by your insurance company as the "payment in full." If your insurance company pays a portion of the fees, you will be responsible for the remaining balance.

REFERRALS: Some insurance companies require a referral from your primary care physician. It is your responsibility to know if your insurance company requires this and to obtain the referral before services are rendered in our office.

CARE CREDIT: We are happy to accept Care Credit for any purchase over $200.00. However, insurance benefits and/or discounts given on services products cannot be combined with Care Credit.

RETURNED CHECK FEE/UNPAID CHARGES: Any check returned for non-payment will be assessed a returned check fee by our collection agency which is your responsibility. Unpaid charges over 60 days will incur a late fee of $15. Accounts with no activity for 90 days may be forwarded for further collection action and will be charged a collection fee of an additional $30. If I default and my account is referred to a collection agency or attorney, I will be responsible for any costs of collecting monies owed, including interest, court costs and attorney fees.

This agreement will be held valid for all future visits until another agreement is signed.

I acknowledge I understand the financial policy and have been offered a copy of the HIPAA Notice of Privacy Practices.

Patient Name: _____ Print Name if different from Patient:_____

Signature of Responsible Party: _____ Date:_____

06/2019

Our office has been working with your insurance companies to ensure we are following the regulations they have set forth. With this, you may notice changes to the way we must bill your visits to our office:

Understanding Your Vision and Medical Insurance:

- ✓ *There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both: Vision care plans (such as VSP and EyeMed) and medical insurance (such as Aetna and Medicare). Vision and medical insurance are quite different in terms of what is covered, and it is important for our patients to understand the difference.* ***As optometrists we are required to abide by the rules set forth by your insurance company****.*

- ✓ *Vision care plans only cover routine vision exams along with eyeglasses and contact lenses. Vision plans only cover a basic screening for eye disease. They do not cover diagnosis, management or treatment of eye diseases or medical eye conditions.*

- ✓ *Medical insurance must be used if you have any eye health problem or systemic health problem (such as diabetes, hypertensive eye changes, or dry eye that has ocular complications). During your exam, your doctor will determine if these conditions apply to you.*

- ✓ *If you have both types of insurance plans, we may be able to bill some services to one plan and other services to the other. This is plan dependent. We will use coordination of benefits to do this and help to minimize your out-of-pocket expense. Each of your insurance plans has deductibles and copays which we are required to collect in your agreement with them.*

- ✓ *We are an intermediary between you and your insurance. We will bill your insurance plan for services if we are a participating provider for that plan. We will attempt to obtain advanced authorization of your insurance benefits so we can tell you what is covered. We encourage you to contact your insurance company as well. It is important to know, insurance does not guarantee the information they are giving us is correct. If some fees are not paid by your plan,* ***the remaining charges will become your responsibility****. We will bill you for any unpaid deductibles, co-pays, or non-covered services as instructed by your insurance contract. If your insurance covers a portion, we have collected from you, we will refund you the difference.*

- ☐ *I prefer to not have my visits billed to insurance and understand I will receive a Prompt Pay. Non-insured discount when I pay in full the day of service.*

- ☐ *I have read and agree with these policies. (Please provide your insurance cards to our staff member if you would like us to file your insurance)*

I authorize Coastal VisionCare to release any information, including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eye care, to third party payers and/or health practitioners, including Medicare. I authorize and request my insurance company to pay directly to Coastal VisionCare benefits otherwise payable to me. I understand my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents and agree to the financial policy for Coastal VisionCare.

_____ _____

Patient signature (parent if child) *Date*

_____

Print Patient name

Thank you for assistance in working with your insurance company.
Drs Heather and Kevin Sorensen
Coastal VisionCare