

Riverbend Eyecare Payment Policy

Thank you for choosing us as your primary eyecare provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

- 1. Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit.
- 2. Co-payments and deductibles.** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Please understand that we are required by law to collect co-payments from our patients at the time of service.
- 3. Non-covered services.** Please be aware that some – and perhaps all – of the services you receive (i.e. Refraction) may be noncovered or not considered reasonable or necessary by Medicare or other insurers; in this event the patient is responsible for all noncovered charges.
- 4. Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
- 5. Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. 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.
- 6. Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
- 7. Nonpayment.** If your account is over 120 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid past 150 days, you will be discharged from this practice. If this is to occur, you will be notified by mail that you will need to find a different source of eyecare.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

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

Signature of patient or responsible party

Date

Effective April 23, 2007 until further notice