

POLARIS EYE & LASER, INC: FINANCIAL POLICY

In the interest of good health care practice, it is desirable to avoid misunderstandings. Our primary responsibility is to help our patients experience good vision and we wish to spend our time and energy toward that end.

Therefore, we wish to inform you to the following:

- 1) To verify benefits and bill your insurance, we require you to provide us with a copy of your insurance card or the company's full name, address, phone number, and policy identifications numbers. Without this information, we will not be able to bill your insurance and payment shall be due from you at the time of your visit. Any co-payments or non-covered amounts are due at the time of service.
- 2) All insurance coverage or benefit information from this office (including those for exams, contact lenses, and glasses) are **ESTIMATES** based on information provided by you and your insurance, and does not guarantee benefits or coverage. We are not responsible in the event the insurance pays less than expected. Any balances not covered by your insurance will be billed to you when we are notified. Notification and billing may take several months after your service date.
- 3) You, as the patient, are responsible for all charges, even if you have the right to be reimbursed by an insurance company or any other third party. We will provide a courtesy billing to your insurance company as a service to you. However, if the insurance has not paid within 60 days from the date of service, you may receive a bill and it will be your responsibility to pay the remaining balance and seek reimbursement from your carrier. Any past due balances more than 90 days from date of service are subject to interest charge of 1% per month.
- 4) We will file all claims to Medicare with a valid signature on file. We will also file claims to your secondary medical insurance.
- 5) If you are not covered by any insurance or Medicare, or if you are covered only by an HMO that Polaris Eye & Laser is not in network, you are considered as a cash-paying patient. Full payment is due at the time of service. If your insurance coverage is only through an international policy or a student policy, we require a full payment at the time of service.
- 6) **REFRACTION POLICY:** Refraction is a measure of the lens power necessary to prescribe glasses or other corrective lenses. Most medical insurance plans, including Medicare, do not cover routine refractions or routine eye examinations. Medicare and private insurance carriers allow us to charge patients separately for the refraction portion of the examination.
- 7) If you need to cancel or reschedule your appointment, we kindly ask you provide at least 24 hours' notice. ALL cancellations and rescheduling done with less than 24 hours of your scheduled appointment are subject to a \$45 cancellation fee.

Financial policy disclosure signature and Assignment of Benefits statement:

I have read and understand the financial policies of Polaris Eye & Laser, Inc. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits. I authorize payment of these benefits directly to Polaris Eye & Laser, Inc. on my behalf and for any service and materials furnished. I authorize release to Medicare and/or my insurance carrier all information needed to determine benefits payable and to process all insurance claims. I am financially responsible for any balance due. If a balance becomes uncollectable, I agree to pay all attorney fees, court costs, and collections fees, reasonably necessary to obtain payment.

Patient or Guarantor Signature _____ Date _____