Cataract & Vision Center of Hawaii

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Financial Policy

Thank you for choosing the Cataract and Vision Center of Hawaii as your eye care provider. We are committed to providing you with quality and affordable healthcare. We are sure you understand that payment for this healthcare is your responsibility. The following information outlines your financial responsibilities related to payment for professional services. Please read this policy, ask us any questions you may have, and sign and date in the space provided.

1. **Payment** is expected at the time of service. We will accept cash, check, or credit card. Collection of the patient's portion of services rendered is part of our contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud under state and federal laws. Please help us in upholding the law by paying your co-payment at each visit.
2. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment is expected in full at each visit. Knowing your insurance benefits is YOUR responsibility. Please contact your insurance company with any questions you may have regarding your coverage and benefits.
3. **Self pay patients.** An uninsured patient who is paying out of pocket for their office visits will receive a 20% discount if payment is made in full on the day of service. This discount is not extended to medications, supplies, or elective procedures.
4. **Proof of insurance and changes in coverage.** All new patients must complete our patient information form before seeing the doctor, this may be done online via our patient portal or completed on a paper form. We must obtain a copy of your picture ID and current valid insurance card(s) to provide proof of insurance. 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. Verification of coverage does not guarantee payment of claims.
5. **Referrals.** Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services. If our doctors are not listed in your plan's HMO network, a written referral from your PCP must be

obtained PRIOR to every visit. If you are a Quest member, as we are a specialty practice, your PCP must be notified prior to every visit. It is the responsibility of the patient to contact their PCP for these referrals. If your insurance company denies claims for services rendered due to lack of proper referral, the patient is responsible for payment in full.

6. **Surgery fees.** We perform surgical procedures in our free-standing Ambulatory surgery Center. When surgery is performed, there is a claim submitted to your insurance for both the surgeon's fee and the facility fee. For procedures requiring anesthesia, the anesthesiologist will file a separate claim to your insurance and bill you directly for your portion of anesthesia services. We will provide you with an estimate of your out of pocket cost at the time of scheduling. A payment of at least 50% of that estimated amount is required prior to your surgery date in addition to any elective procedure payment.
7. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to 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 remember that insurance is a contract between the patient and the insurance company and ultimately, the patient is responsible for payment in full if your insurance company does not pay the practice for services rendered.
8. **Nonpayment.** An account that remains unresolved for more than 90 days is considered delinquent. The office may refer these accounts to a third party collection agency.
9. **Collection fees.** I understand that in the event my account is placed in collection status, any additional fees incurred due to this will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.
10. **Returned checks** will incur a $10.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $7.00 service charge.
11. **Payment plans.** Please let us know if you have difficulty paying your account. We may be able to help you by setting up a payment plan based on your financial hardship. Call (808) 524-1010 for assistance.
12. **Missed appointments.** Our policy is to charge $10.00 for missed appointments not canceled 24 hours ahead of the appointment time. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment.
13. **Release of information.** I herby authorize the Cataract and Vision Center of Hawaii to release to insurance carriers or others who are financially liable for

such professional and medical care, all information needed to substantiate claim and payment.

14. **Assignment of benefits.** I herby authorize and direct my insurance carrier(s) to pay directly to the physicians of the Cataract and Vision Center of Hawaii any benefits due under my insurance plan. I permit a copy of this authorization to be used in place of the original.

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

_____ _____

Signature of patient or responsible party Date