

BOSTON EYE CARE CONSULTANTS

Robert A. Lytle, MD

FINANCIAL POLICY

* **PLEASE INITIAL BY YOUR INSURANCE TYPE** *

 HMO PLANS ALL CO-PAYS ARE REQUIRED AT TIME OF SERVICE. There can be no exceptions due to contracting and uniform compliance rules. You are responsible for getting proper referral information and authorizations in advance of your appointment. You will be responsible for payment for services denied by your HMO for lack of referral and/or pre-authorization.

WE REQUIRE ALL REFERRALS TO BE IN PLACE PRIOR TO EACH VISIT OR WE WILL RESCHEDULE YOUR APPOINTMENT

 PPO PLANS We have agreed to accept the discounted rate for our insurance plan, however all co-insurance is your responsibility, **ALL CO-PAYS ARE REQUIRED AT TIME OF SERVICE.**

 MEDICARE As a participating provider, we will bill your Medicare carrier. You are responsible for your annual deductible and 20% co-insurance and we must collect that. We will be happy to bill your secondary insurance as well. If a balance remains after we bill Medicare and your secondary insurance, we will bill you for the balance, which is payable upon receipt of our statement.

 SECONDARY INSURERS Having more than one insurer DOES NOT necessarily mean that your services are covered 100%. Secondary insurers will pay as a function of what your primary carrier pays. We will bill your secondary insurance as a courtesy. You are responsible for any balances for any balances after your primary and secondary insurance clear. **WE DO NOT BILL TERTIARY INSURANCE.**

 STATE INSURANCE We take most state health insurance plans, although it is up to you, the patient to obtain an insurance referral, if a referral is required. **IF YOU REQUIRE A REFERRAL BUT DO NOT HAVE ONE AT TIME OF APPOINTMENT WE WILL NEED TO RESCHEDULE YOU TO ANOTHER TIME.**

 SELF PAY You are required to pay for your visit **IN FULL** at the time of your visit.

 MINOR PATIENTS The adult accompanying a minor and the parents/or (guardians) of the minor are responsible for presenting the patient's insurance information or payment in full at time of visit.

WE ACCEPT MASTERCARD, VISA, AMERICAN EXPRESS, DEBIT CARD, CHECK AND CASH

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PLEASE INITIAL EACH OF THE FOLLOWING



_____ SERVICES NOT COVERED BY YOUR INSURANCE We will try to provide prior notification if you are going to receive a service that we know is not or may not be covered by your insurance. Some of these services may include refraction or premium intraocular lenses with cataract surgery.

_____ ABOUT YOUR INFORMATION We require you bring your insurance card with you to every visit. **IT IS YOUR RESPONSIBILITY TO KEEP US INFORMED OF ANY CHANGES IN YOUR INSURANCE COVERAGE.**

_____ RECORDS There will be a \$25 charge for printing materials from your chart. Certified return receipt for mailing is an additional \$6.00. There is **NO** charge to transfer records electronically to another medical facility. We require a signed Records Release form prior to sending your records. **WE DO NOT SEND RECORDS THROUGH EMAIL FOR THE SAFETY OF OUR PATIENTS INFORMATION.**

_____ RETURN CHECK FEE There is a \$75.00 banking fee for all returned checks. If your check is returned from the bank we will not accept a check as payment on your account. Future payments must be made with cash, money order or credit card.

_____ NO-SHOW FEE There is a NO-SHOW fee policy in which you will be charged \$25.00 if you do not cancel your appointment 24 hours prior to your appointment date.

I understand and agree that I am responsible for all changes pertaining to my medical care, regardless of my insurance status. It is also my responsibility to inform your office of any contact information like mailing address and phone number. We require you to bring your insurance cards and photo I.D. with you to every visit. I have read, understand and agree to the Financial Policy. I have completed the patient information forms, the information is true and correct to the best of my knowledge. I will notify your office of any changes that need to be changed in my chart.



Patient Signature: _____



Date: _____