

KAY, TABAS, NIKNAM & DIDOMENICO OPHTHALMOLOGY ASSOCIATES

Ophthalmic Medicine & Surgery

PATIENT FINANCIAL POLICY

Thank you for choosing our office for your ophthalmology health care needs. We have some basic guidelines concerning insurance and financial requirements. These guidelines help us to control health care costs by reducing our billing and collection costs. **The law requires us to collect all copayments, deductibles, percentages or non-covered services, at the time of service.** If we do not collect payments, your insurance company can charge us with fraud. Failure to pay your co-pay the day services are rendered will result in additional charge of \$25.00.

This office contracts with many insurance carriers including Medicare, Blue Cross Blue Shield, and Aetna. Please check with our reception staff to determine whether your plan is one of these. Please be advised that if your insurance requires a **referral**, it is your responsibility to obtain one.

If we have a contract with your plan, we will be glad to submit claims to your insurance company if you provide us with all necessary information. You are responsible for any part of your bill not paid by your insurance company. Your insurance company has 60 days to respond to our claim. If your carrier has not responded in 60 days, or if your claim is denied or partially paid, you will have to pay the balance, unless it is contractually stated that you will not be billed. We will do everything to assist you in getting payment from your insurance carrier.

To minimize administrative costs, if you are more than thirty (30) days late in the payment of any bill connected with this treatment, and past treatment, a finance charge of **1.5%** per month will accrue on the unpaid balance; and if a delinquent account is referred to an attorney, you agree to pay the attorney's fee, court costs, and collection agency fees associated with the collection process.

MISSED APPOINTMENTS: In order to provide the best possible service and availability to all our patients, it is our policy to charge a fee of **\$35.00** for any appointments not cancelled at least 24 hours prior. Please call us as early as possible if you know you will need to reschedule your appointment. Three missed appointments could result in being discharged from the practice.

For all returned checks there is a **\$35.00** fee. We will not be able to accept another check until the returned check and fees are paid in full.

If you do not have one of the plans with which the practice is contracted, **the total cost of your visit is required at the time of service.**

If at any time you are concerned about the cost of a procedure proposed by the doctor, you may ask for someone from the financial department who will be happy to discuss the cost with you.

For your convenience, this office accepts MasterCard, Visa, American Express and Discover, in addition to cash and checks. Thank you for your understanding and cooperation.

I certify that I have read the financial policy of Kay, Tabas, Niknam & DiDomenico Ophthalmology Associates and agree to abide by the policy.

Print _____ Date _____

Signature _____ Date _____