Our Patient Financial Policy

Thank you for choosing Mid Ohio Eye to serve your healthcare needs. We are committed to your successful treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to any treatment. Our practice firmly believes that a good physician and patient relationship is based upon understanding and good communication. We believe that an informed consumer is a more satisfied patient. Therefore, we want to communicate our Patient Financial Policy to you in writing so that you will know what to expect at the time of your visit.

Insurance

All patients must complete our patient registration form and provide current information before being seen by the doctor. We accept assignment from many medical and vision insurance companies, but in the event that your insurance does not cover your visit or treatment within a reasonable time (45-60 days) the balance may automatically be transferred to the patient's responsibility. Please be aware that some of the services provided may be non-covered services and considered not reasonable and necessary under Medicare and/or other medical insurance guidelines.

We must emphasize that as medical care providers, **our relationship is with you, not your insurance company**. We will appeal disputed claims with insurance companies to the extent additional documentation is required from us in order for your claim to be processed. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of what those rates should be.

All co-pays, deductible, and balances owed are due at time of service. If your insurance applies any of your charge to your annual deductible or coinsurance, that portion is due and payable by you at the time of service. If you have elected to use our practice and our physicians out of your network of coverage please check with your insurance regarding benefit levels. Your employer or provider of insurance determines your benefit coverage by contracting with a particular insurance company. If you have questions regarding your coverage, please speak with your human resources representative or use the payer web address listed on your card. **It is your responsibility to understand your benefit coverage**.

High Deductible Health Plans (HSA, HRA, FSA participants)

Please inform us prior to your visit if you are a participant in a High Deductible Health Plan (HDHP), a Health Savings Account (HSA), a Health Reimbursement Arrangement (HRA) or a Flexible Spending Account (FSA). You must be prepared with the plan information and **pay the patient responsible portion** from the HSA, HRA or FSA **at the time of service**.

Patient Responsibility

If you are seeking a non-covered service, do not have insurance, or if you are a participant in an insurance for which we are not a provider, we require that you be prepared to pay our fees at the time services are rendered. Please inquire with our staff about self pay cash discounts for payment at the time of service. If you are covered by insurance your bill will be reduced to our contracted allowable amount.

If you have a work related illness or injury, please notify our receptionists upon arrival to ensure the proper paperwork is completed before your visit.

We realize that temporary financial problems may affect timely payment on your account. If such problems arise, or in circumstances where a claim is pending or when treatment will be provided for an extended period of time, it is recommended that a payment plan be initiated. We encourage you to contact our billing office at (888) 572-1181 for prompt assistance in the management of your account.

Payment Details

We accept cash, check, and most major credit cards. We have the capability to accept payments over the phone with your debit or credit account information. We reserve the right to process your payment electronically based on information you provide to us.

If you are having surgery, the surgery center and anesthesiologist are separate providers from us. Payment for services performed at any facility outside our office needs to be discussed with that facility.

Any returned checks are subject to a $35.00 fee. Returned checks must be resolved before any future appointments can be scheduled.

Minor Aged Patients

Adults accompanying minor patients (parents or guardians) will need to complete a Release of Liability and Permission form. The parent or guardian accompanying the minor is responsible for payment of any fees for that minor not covered by insurance. For unaccompanied minors, treatment will be denied unless we have received the proper paperwork. Insurance cards need to list the minor's name.

Missed Appointments

We ask that if you are unable to keep an appointment, that you call us as early as possible to reschedule. In order to provide the best possible service and availability to all our patients, it is our policy that if you miss three or more appointments, we may refuse to continue providing care to you.

Account Delinquency and Credit Reporting

An account is considered delinquent and may be referred for collections if payment in full is not made in a timely manner. If you are unable to adhere to an original payment agreement you must contact us to discuss alternative arrangements. If payment arrangements are not made and/or payment in full is not made, your account with us would be referred to collections, and your credit history may be obtained.

We also reserve the right to bill a collections fee in addition to the outstanding amounts owed for services rendered. All outstanding balances must be paid off in order for future visits to be scheduled. If not resolved in a timely manner, we reserve the right to dismiss you from our practice.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Name of Patient or Guarantor	Signature	Date
Employee Name (Witness)	Signature	Date