



FINANCIAL POLICY

Thank you for choosing Northern Vision Eye Care for your eye care needs. Northern Vision Eye Care is a free standing facility providing ophthalmology services rendered by Robert K. Butryn, MD and optometry services by Jennifer A. Lintz, OD. We are committed to providing you with the best possible care. In an effort to ensure the billing process goes as smoothly as possible it is important that you understand our office policies. We are happy to discuss any questions you may have. Please read the following information and sign in the space provided. Keep a copy for your records.

As a courtesy, insurance claim forms will be prepared and sent to your insurance company on your behalf. Your insurance company may contact you directly requesting additional information. A statement for your deductible, co-insurance, and/or any non-covered charges will be sent to you as soon as we receive either payment or denial from your carrier. Balances are then due upon receipt of the statement unless prior arrangements have been made. Please be aware that the balance on your account is your responsibility whether or not your insurance company pays the claim. Accounts with unpaid balances may be forwarded to a collection agency. Personal checks that are returned for non-sufficient funds are subject to administrative fees.

Co-pays are required at the time of service. You will be billed for deductibles or any additional co-pay as indicated by your insurance company at the time of their payment. We try our best to collect the correct co-pay amount from you at the time of service.

Please be advised that the contract between you and your insurance company is a separate contract from that between you and our clinic. **It is your responsibility to be knowledgeable of your own insurance coverage/benefits/eligibility and to alert our staff should your coverage change or be discontinued.**

All patients are required to complete our patient information form. **You will be asked to verify your address, phone, and insurance information at each visit.** If current health insurance information cannot be provided at each visit you will be responsible for payment in full.

Workers Compensation or automobile accident claims will be billed directly to the carrier in accordance with Michigan law. Payment of any disputed or denied claim will be your responsibility.

We kindly request at least 24 hours notice when canceling or rescheduling your appointment. It is difficult to fill a canceled or rescheduled appointment – especially when given little or no prior notification. If you need to change an appointment please extend the courtesy of giving us enough time so we can treat another patient. Our office does not charge for missed appointments, however; if you have missed 3 appointments, you may be asked to seek another health care provider. Please help us provide the best care for you and our other patients by keeping your scheduled appointment.

Refills may be called in during regular office hours. Please have the following information available when you call one in: patient's name, date of birth, phone number, name of medication, strength and dosage, and the pharmacy you want it called in to. **Please allow 48 hours for medication to be called in to your pharmacy.**

I have read and understand the office policy and agree to abide by its guidelines.

Print patient name

Date of birth

Signature of patient or responsible party

Date

What is a co-pay and co-insurance?

A **co-pay** is the small amount you have to pay to access medical care according to your insurance contract. In some cases, it might be \$10-\$30 but with some insurances, it would be a percentage of your bill (10% is common). This serves as an incentive for you to visit the doctor less and thereby avoid the over-use of medical services. **Co insurance** is the remaining balance after the insurance company has paid their portion. With the new Medicare products being offered by commercial insurance companies, some Medicare patients do have a co-pay as well as their co-insurance to pay.

What is a deductible?

A deductible is the amount of money that a patient must pay out of pocket before the insurance company is responsible for any charges. The average deductible ranges from \$100 to \$1500 and once this is met by patient the insurance company will begin to pay for covered charges. Medicare patients are responsible for their deductible at the beginning of each year.

Why do I have to pay my co-pay and/or deductible?

When you sign up with an insurance carrier, you sign a contract which stipulates that you are obligated under the conditions of that contract to pay your co-pay and/or deductibles. This means you are required to pay a co-pay and/or deductible for all office visits, including follow up examinations and outpatient surgical procedures done in our office, etc.

Why do you collect the co-pay instead of billing me like my last doctor?

It is much more efficient to collect the co-pay at the time of service. Otherwise, it becomes more difficult and expensive to deal with administratively. It needs to be entered in the computer, bills must be mailed, and our billing person must then track the amount for payment, etc. Higher administrative costs in the office ultimately result in higher medical costs for the patient. This policy is non-negotiable.

Why can't you just "write off" my co-pay and/or deductible?

Since your insurance contract stipulates that you must pay a co-pay and/or deductible, waiving this fee would violate your contract. When we signed up with your insurance company our contract states we will collect co-pays and/or deductibles owed by the patient. If the doctor gives you a "discount" by waiving your co-pay and/or deductible and then bills the insurance company without giving them the same "discount", it would be considered insurance fraud.

AUTHORIZATION TO PAY/AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize my insurance company to pay Northern Vision Eye Care for all services rendered. I understand that I am responsible for any co-pays, deductibles, co-insurance amounts, and non-covered services.

I request payment of Medicare benefits on my behalf be made directly to NVEC – commonly referred to as assignment of benefits. I certify that the information given for payment under title 18 of the Social Security Act is correct.

I hereby authorize NVEC to obtain and release information regarding my condition and/or treatment only to my physician, insurance company, or employer (if workers comp). NVEC agrees to comply with all HIPAA and state patient privacy requirements. Upon my request, I may obtain a copy of the HIPAA policy.

I have read and understand the above authorization and information sections or have had them read and explained to me to my satisfaction.

SIGNATURE OF PATIENT: _____

PARENT OR GUARDIAN IF PATIENT IS MINOR: _____

DATE: _____