

## FINANCIAL POLICY

The following outlines the financial policies that our office follows. We encourage you to discuss your account, and ask any questions. Your understanding of our policy early on in your treatment process will prevent most concerns and issues in the future.

### INSURANCE

- All co-payments and/or coinsurances will be collected at time of service.
- We will file claims on all visits and procedures to your **medical** insurance.
- Accounts will be balanced to match the insurance explanation of benefits (EOB) and any remaining balance will be forwarded to you, the patient.
- You are responsible for **ALL** balances **NOT** paid by your insurance.
- **Please remember insurance coverage is a contract between the patient and the insurance company. The ultimate responsibility for understanding your insurance benefits and for payment to your doctor rests with you.**

### REFERRALS

- You are required to:
  1. Know whether or not your insurance requires a referral.
  2. Obtain that referral before you are scheduled to visit our office.
- We will require payment in full on day of service if you do not obtain a referral.

### NON-COVERED SERVICES

- Insurance companies will only pay for services that they find “reasonable and necessary”.
- You are responsible for payment of any services denied by insurance.

### REFRACTION SERVICE AND FEES

- Refraction is the process to determine if there is a need for eyeglasses, and is an essential part of an eye exam. It is considered a routine vision service.
- Most medical insurance plans, including Medicare, do **NOT** cover routine refractions.
- The fee for refractions is **\$55.00** and is collected at the time of the service.

### PAYMENT

- Payment may be made by: Cash, Check, Credit/Debit Card, and Money Order.
- Cards Accepted: **DISCOVER, MASTERCARD, and VISA** (we do not accept AmEx or Diners)
- **A fee in the amount of \$35.00 will be charged for all returned checks.**

### PAST DUE ACCOUNTS

- Account balances should be handled promptly, and will be considered past due after 120 days with an outstanding balance. All past due accounts will be turned over to a collection agency, and a fee of 20% of past due balance will be added to your account.
- We will require full payment before seeing the physician for any future services.

**PATIENT STATEMENT  
OF  
FINANCIAL RESPONSIBILITY**

Please initial each of the following statements to acknowledge that you have read and agree.

\_\_\_\_\_ I acknowledge that I have been informed of Karen B. Saland, MD, PLLC's financial policy.

\_\_\_\_\_ I understand that my insurance company may deny payment for my office visit for the reasons stated in the financial policy.

\_\_\_\_\_ I recognize that I am personally and fully responsible for payment of any services denied by insurance.

\_\_\_\_\_ I agree to the terms of this Financial Policy.

\_\_\_\_\_  
*Print Patient's Name*

\_\_\_\_\_  
*Signature of Patient/Guardian*

\_\_\_\_\_  
*Date*