FINANCIAL / OFFICE POLICIES

Forms & Payment: All patients must complete patient and insurance information sheets prior to treatment. Payment for your care is considered part of your treatment. Services not covered by your insurance are due in full at time of service. If you do not have insurance, we expect payment in full at time of service.

Claims Filing: We are happy to file your insurance claim directly with your insurance company. Our insurance claims are computerized to ensure proper filing. It is vital we are provided with your most current insurance information in order to get your claim paid. We prepare and file insurance claims for services you receive. However, it is your insurance contract, and we look to you for payment, not your insurance company. Co-pays and/or non-covered services not paid at time of service require a non-payment fee of $10.00 attached to that day's visit. All balances are due within 30 days of the statement date.

Refractions: Patients new to Abrams EyeCare, patients not seen in over one year or with significant vision changes may require a refraction. When a refraction is performed on your eyes there is a $40.00 fee. **Refractions are not covered by Medicare or most other insurance plans.** Patients are responsible for $40.00 refraction fee and payment is due at time of service.

Prescriptions & Refills: Requests are handled during office hours and can take up to 3 business days to process. Prior Authorizations to insurance companies for medications is time consuming for our staff. There is a $20.00 fee if you request our assistance completing forms including prior authorizations for prescriptions and refills.

Medical Records Copying & Form Completion: Requests for copies of medical records are subject to a fee set by Indiana Law. If records are mailed, there is an additional postage charge. $10.00 fee to complete form(s) for the BMV and a $30.00 charge for all other Organizations and/or forms, such as FMLA.

Statement of Managed Care Responsibilities: We are enrolled in numerous managed care programs. It is difficult keeping track of every requirement of every plan. Within the same insurance company plans may differ depending on contracts your employer negotiated. If you do not inform us of pre-authorization/referral requirements in your contract, and we treat you without required authorization/referral, we must bill you directly for our charges.

Medicare, HMO, Medicaid & Commercial Plans: We are contracted with Medicare to accept assignment of Medicare benefits for our services. We will complete and submit Medicare insurance forms. Medicare will pay its share of the bill directly to us. You will be responsible for annual deductibles, co-insurance, and all other non-covered charges. My signature authorizes release of medical information necessary to pay directly to Abrams EyeCare Associates the amount(s) due on my claim for services rendered to my dependent(s) or to me.

Acknowledgment of Coordination of Benefits with Your Vision Plan: If you are a member of EyeMed Vision Care or Vision Service Plan (VSP) we may bill your vision plan as secondary coverage to your medical plan if testing is done today in addition to your comprehensive medical exam. You will only pay for one copay today (the lesser copay amount) for this visit.

Treatment of Minors: The parent or legal guardian who brings a minor to the office for treatment shall be responsible for all medical bills incurred at that time.

Agreement to Financial & Office Policies: I have read and thoroughly understand this Financial Policy and I accept financial responsibility as described in this policy. I will be responsible to Abrams EyeCare Associates for payment of the entire amount for today's and all future service(s) rendered to my dependent(s) and to me. I further agree, if any balance is not paid when due, to pay all cost of collections, collection agency fees, including reasonable attorney fees and court costs. If I am agreeing and signing on behalf of a minor patient, I affirm that I have the legal right to consent and agree on behalf of that minor.

If any, or all, of the above Financial and Office Policies affect your service(s), please sign for responsibility. Should you have any questions after your visit you may contact our Billing Staff at 317-819-0742.

Patient Name	**Date of Birth**
Signature of patient or legal guardian	**Date**