W. Lee MacKewiz, O.D., P.A. (WLM OD PA)

OUR FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. A clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. We accept **CASH**, **VISA/MASTERCARD, DISCOVER, DEBIT CARDS AND AMERICAN EXPRESS** as payment for professional services. **WE DO NOT ACCEPT CHECKS**.

MINORS: Parents or legal guardians are responsible for full payment at the time of service. MINORS NOT ACCOMPANIED by a parent or legal guardian will be denied service unless payment is made by cash or has been pre-authorized on a credit card IN ADVANCE.

INSURANCE: **INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY**. We are not a party to this contract. (We will advise you if we are a participating provider with your insurance company, and we will handle your claims according to our agreement with the insurance company.) We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual & customary" charges, etc. other than to supply factual information as necessary. **YOU ARE RESPONSIBLE FOR PAYMENT OF YOUR ACCOUNT INCLUDING DEDUCTIBLES, CO-PAYS, AND CO-INSURANCE AT THE TIME OF TREATMENT**. In order to keep our fees as low as possible, it is impossible to spend the amount of time on paperwork necessary to receive payment from more than one insurance company. **WE WILL REQUIRE PAYMENT OF ANY BALANCE NOT PAID BY THE PRIMARY INSURANCE**. If you receive payment from the insurance company for services rendered by WLM OD PA, you must reimburse WLM OD PA immediately upon receipt of such payment. If your insurance company pays us more than the balance due, our office will refund the amount owed to you. We do not represent insurance companies and you should discuss your specific coverage with your carrier yourself.

IT IS YOUR RESPONSIBILITY TO NOTIFY US OF ANY CHANGES IN YOUR COVERAGE. IT IS YOUR RESPONSIBILITY TO KNOW YOUR BENEFITS. REFERRALS AND TREATMENT AUTHORIZATION ARE ULTIMATELY YOUR RESPONSIBILITY. Any visits that are not covered by your insurance company because you have not obtained authorization or have not presented a valid referral become solely your responsibility. We will bill your insurance company no more than two (2) times. If repeated billing of your insurance carrier does not provide payment of your bill, we will have no choice but to look to you for full settlement of your account. Please ensure that you have submitted the appropriate insurance.

MEDICARE: If you are covered by Medicare or any other government program, please discuss your payment situation with our office staff prior to your examination. **DEDUCTIBLES, CO-PAYMENTS AND NON-COVERED SERVICES MUST BE PAID BEFORE LEAVING THE OFFICE.**

MISSED APPOINTMENTS & LATE CANCELLATIONS: If you must cancel, PLEASE PROVIDE 24 HOURS NOTICE so we have time to fill your appointment. Failure to show up for appointments or last minute cancellations will prevent our office from scheduling you in the future. Furthermore, **WE WILL CHARGE FOR CANCELLATIONS LESS THAN 24 HOURS PRIOR TO YOUR APPOINTMENT AND FOR "NO SHOW" APPOINTMENTS.** Missed appointments without 24 hours notice will be BILLED TO YOU, not your insurance carrier.

COLLECTION AGENCY FEES: **A $15.00 PER MONTH LATE FEE** will be assessed on all past due balances. If WLM OD PA must engage the services of an attorney, collection agency, or other lawful method of collection, you will be responsible for the original balance, late fees and all additional costs that our office incurs for the collection process.

AUTHORIZATION TO RELEASE INFORMATION: I understand and agree that (regardless of my insurance) I am ultimately responsible for charges to my account for all services rendered to me or my dependent. I authorize WLM OD PA to furnish the appropriate agencies, for the purpose of billing, any information acquired during the course of my examination. All records released require an **ADMINISTRATION AND COPYING FEE** paid to WLM OD PA before they are released, regardless of requestor.

I UNDERSTAND THAT I WILL BE CHARGED FOR LATE CANCELLATION AND FAILURE TO SHOW UP FOR APPOINTMENTS. I understand and agree to this Financial Policy.

Signed _____ _____ _____

(Patient, Parent/Guardian) (Date) (Social Security No.)

Thank you for choosing Bear Eye Associates for your vision care!