Adirondack Eye Care Center

Financial Policy

Thank you for choosing Adirondack Eye Care Center for your optical care. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc.).

Co-pays

The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at the time of check out unless previous arrangements have been made with our billing coordinator. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted. All returned check will have a processing fee of $35 added to your balance.

Insurance Claims

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of the contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits.

Referrals and Preauthorization's

Certain health insurances (HMO, POS, etc.) require that you obtain a referral or prior authorization from your Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment arrangements or rescheduling of your appointment may be necessary if not obtained.

Outstanding Balance Policy

It is our office policy that all past due accounts be sent two statements. If payment is not made on the account, a single phone call will be made to try to make arrangements. If no resolution can be made, the account will be sent to the collection's agency.

_____

Patient Name

_____ _____

Signature of patient / responsible party Date

This financial policy helps the office provide quality are to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us @ 315-942-2122

Adirondack Eye Care

151 Main Street, Suite 1, Boonville, NY 13309
(315) 942-2122

SIGNATURE ON FILE

PLEASE CHECK ALL THAT APPLY

- ❑ I acknowledge that I have been presented with a copy of the Notice of Privacy Practices from the office of Adirondack Eye Care, Inc.
- ❑ I authorize use of this form on all my insurance submissions.
- ❑ I authorize release of information to all my Insurance Companies.
- ❑ I understand that I am responsible for my bill.
- ❑ I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies.
- ❑ I authorize payment direct to my doctor.
- ❑ I permit a copy of this authorization to be used in place of the original.
- ❑ I authorize release to my _____ (Relationship) _____ (Name) pertinent medical information.

NAME _____ (PLEASE PRINT) MEDICARE# _____ (IF APPLICABLE)

SIGNATURE _____ DATE _____