FINANCIAL POLICY AND BILLING PROCESS
GREENBERG LASER EYE CENTER

- **Copay, Co-insurance and Deductibles:** It is my responsibility to know what my copay, co-insurance and deductibles are, and my obligation to pay this at the time of service. If I am not able to pay my co-pay, deductible or coinsurance portion at the time of service my appointment may be rescheduled or subject to a $15.00 fee.
- **No Show Appointments:** All appointments that are not canceled within 48 business hours of the appointment time are subject to a $40.00 fee. This $40.00 fee must be paid before we can reschedule your appointment.
- **Refractions:** Refraction is the process of determining if there is a need for corrective eyeglasses. It is an essential part of an eye examination and necessary in order to write a prescription for glasses or contact lenses. Medicare and most medical insurances do not cover this service. I understand that I am responsible for this $36.00 fee due at the time of service.
- **Contact lens fitting:** There is a $120.00 contact lens fitting fee charge for first time wearers and a $60.00 charge for an established wearer.
- **Insurance Coverage:** I acknowledge that the insurance cards I have presented are current and accurate. If we have not received payment after 90 days, our office reserves the right to send the entire bill to the patient for payment. It will be your responsibility at that point to contact your insurance company with any questions or concerns regarding your bill.
- **Medical vs Vision:** Your **medical insurance** is billed if a medical condition is discovered during your examination.
    - Evaluation of an ocular disease you have been diagnosed with (e.g., glaucoma, cataract, corneal, or retinal disease). A complaint such as redness, tearing, burning, or other pain or discomfort to the eyes.
    - A history of or new onset of floaters, flashes of light, or other visual disturbance.
    - To follow an existing chronic condition such as diabetes, corneal disease, dry eye syndrome, an autoimmune disease, or if you take high risk medications like Plaquenil.
    - If you are scheduled for additional testing such as visual field, OCT, or retinal photography.
    - If your visit requires a report to your primary care physician.
- **Participating Insurance Plans:** If GLEC is not a participating provider in my insurance plan, I will be responsible for filing my own claims and I will be responsible for paying in full at the time of service.
- **Non-covered Services:** I understand that some services may be considered non-covered services by my insurance plan. I understand that it is my responsibility to know what my insurance does or does not cover and I understand that I am financially responsible for paying all non-covered services.
- **Denied Charges:** I understand that some charges may be denied by my insurance carrier as investigational, experimental or not medically necessary and will not be paid by my insurance carrier. I understand that my physician feels these services are needed whether my insurance carrier deems them payable or not and that I am obligated to pay for these services in full.
- **Returned Checks & Past Due Accounts:** Returned checks will be subject to collection charges of an additional $25.00 with penalties and interest. All accounts are considered past due if not paid within 90 days of service. Past due accounts may result in collection turnover and be subject to penalties and interest, or the refusal of future appointments until old balances have been paid in full. The practice does not accept post dated checks.
- **Surgery Charges:** The practice will make every effort to determine your insurance benefits and to relay to you what you will owe for surgery charges, please keep in mind that this is just an estimate. Please be aware that when surgery is performed, you may incur additional charges (in addition to the surgeon's fees) from the surgery facility, anesthesiologist, laboratory or radiologist.

X_____

Patient/Representative Signature Date

Printed Name _____