There is always confusion with regard to the patient Co-payment and Deductible amounts. It is the POLICY of this office not to release patients of their financial obligations set forth by the various insurance carriers you have health insurance coverage through. If you are dissatisfied with the amounts you are contractually obligated for, you will need to contact the administrator of your health plan to see what other options for coverage are available to you.

If you have a pre-determined co-payment, ($20, $30, etc) please be prepared to pay it at the time of check-out. Co-payments not collected at the time of service will be assessed with an additional $25 processing fee. If you are responsible for a percentage (20%, 10%, etc) of the allowed amount set by your insurance carrier, we will send you a statement indicating your share, once payment has been received from your insurance carrier. We gladly accept cash, check and credit cards. If you have ever provided us with a non-sufficient fund check, we will accept cash or credit card for future visits. If you present to a visit without means to pay for your portion, we will reschedule your visit for another date when you are able to pay. The waiver of co-payment of deductible amounts has been determined to be an act of fraud against the insurance carriers we participate with, Our office is committed to providing the highest quality of care to our patients and as well as upholding the contracts of those insurance carriers we participate with.

If your insurance company requires a referral, it is your responsibility to obtain this referral prior to your appointment or you will be responsible for the payments.

If there are any medically necessary procedures that most insurance plans do not cover, these will be discussed with you so you understand your responsibility for payment of these charges should they be performed.

We are sensitive to those situations which would preclude a patient from receiving care due to financial hardship. If you believe you have a financial hardship, please speak with our business office for alternative payment methods and plans.

If you have an outstanding balance from previous visits or a hospital stay where we provided medical care for you, you will be required to satisfy those outstanding amounts prior to receiving additional care. The balance of the account is to be paid in full unless a payment plan has been arranged for you with the billing office. If you are being asked to pay for services you believe you have not received, make our business office aware of your concerns and will will resolve any errors on our part as quickly as possible.

Please be advised that, in the event you consistently fail to pay co-payments and balances as per the contract with your insurance carrier, we are obligated to notify them in writing of the compliance issue. Additionally, if you have continued financial concerns and are unable to satisfy the contractual obligations you have with your insurance carrier, we will provide you with a list of free clinics int the area.

If your account is currently in collections and you are not actively paying on that account, we will not schedule any further visits for you until your balance is paid.

If you require completion of forms by the physician, there will be a $20 processing fee.

We appreciate your time and attention to this information and look forward to continuing to serve your medical needs. If you have any questions, comments or concerns, please direct them to our Practice Manager.

FINANCIAL RESPONSIBILITY
I have read and understand the payment policy of Adelson Eye & Laser Center and its contractual obligation to my chosen insurance carrier. I understand that I am responsible to pay for services rendered at the time of service, including all reasonable attorney's fees and costs of collection in the event of default.

_____   _____
Patient Signature (or person authorized)   Date

_____   _____
Witness   Date