FINANCIAL POLICY

PLEASE REVIEW, SIGNATURE IS REQUIRED

We are dedicated to providing you with the best possible care and service and regard your understanding of our financial policies as an essential element of your care and treatment. The following is our financial policy, if you have any questions; please feel free to discuss them with our staff.

All patients are ultimately responsible for their own bill. Patients who have health care coverage, Medical and/or Vision, are responsible for providing the office with complete and accurate information regarding their insurance. You are responsible for obtaining necessary referrals for your initial office visit – the office will request referrals for additional visits and surgeries.

Patients without health coverage are expected to pay in full at the time of service.

For your convenience we accept cash, checks, debit cards, HSA debit cards, VISA, MASTERCARD, DISCOVER, and AMERICAN EXPRESS. We also offer financing options.

MINOR PATIENTS:
These policies apply to minor patients also. We strongly recommend the minor's responsible party accompany them to the office. If this is not possible the adult accompanying the minor is responsible for seeing that our policies are met. (Minors and adults other than the responsible party cannot sign office paperwork).

INSURANCE:
We have made prior arrangements with many insurers and other health plans. We will bill those plans with which we have an agreement and will collect any *required copayment at the time of service.* We bill your secondary insurance as a courtesy, after the primary insurance finalizes. In alignment with our efforts to keep overall health care as efficient and cost-effective as possible, we collect your portion of our fees, including deductibles, refractions and copays, at the time of your appointment. If your health plan determines a service to be "not covered," you will be responsible for the complete charge. In that event, we will bill you and payment is due upon receipt of our statement.

If you have a managed care plan that requires a referral to see a specialist, you must obtain a referral in order for your visit in our office to be covered under your medical insurance. If you do not have the valid referral and still wish to be seen, you will be asked to pay for the visit prior to your examination. A refractive examination is not a covered service by medical insurance companies, including Medicare. In addition, some charges may be arbitrarily denied by insurance carriers as "investigation, experimental, or not medically necessary" and will not be paid by the insurance carrier. If the physician feels these services are needed and standard of care whether the insurance carrier deems them payable or not, you are obligated to pay for these services in full.

If your insurance plan is one with which we do <u>not</u> have a prior agreement, we will prepare and send the claim for you on an unassigned basis. In this case, your insurer will send the payment directly to you; therefore, charges for your care and treatment are due at the time of the service.

It is the patient/parent/guardian's responsibility to:
- Be familiar with the benefits of your plan, including co-pays, co-insurance and deductibles.
- Bring all of your current insurance cards to all visits.
- Provide our office with current information including address, phone numbers and employer.
- In accordance with your insurance contract, you must be prepared to pay your co-pay at each visit.

ASSIGNMENT OF BENEFITS:
I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, Medicare and other government sponsored programs, private insurance and any other health plans, to Midwest Vision Partner entities. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the assignee to release all information necessary to secure the payment of benefits.

ACCOUNT BALANCES:
We appreciate prompt payment in full for any outstanding balance. If your account is turned over to our collection agency, you agree to pay any fees imposed by the collection agency to collect the overdue amount. You may not schedule an appointment until your balance has been paid in full. Any check payments that do not clear the bank will be subject to an administrative returned check fee. There is a charge for completing various forms, including your DMV form. Pre-payment is required for completing forms, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. Any credit balance on your account will be applied to any remaining patient responsibility balance for any MVP entity before a refund is issued.

CANCELLATIONS/RESCHEDULING:
We kindly request at least a 24-hour notice when canceling or rescheduling your appointment. Missed appointments could be used to treat other patients in need of care. No Show/missed appointments may be charged a service charge per practice policy. Please help us provide the best care for you and our other patients by keeping your scheduled appointment.

INFORMATION RELEASE:
Midwest Vision Partners may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug use, psychiatric illness, communicable disease, or HIV, to any person or corporation which is or may be liable or under contract to Midwest Vision Partners for reimbursement for services rendered, or any health care provider for continued patient care. Midwest Vision Partners may also disclose on an anonymous basis any information concerning my care, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for statistical data collection or pursuant to State or Federal law, statute, or regulation. A copy of this authorization may be used in place of the original.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____ _____
Signature of Patient or Responsible Party Date

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Please Print the Name of the Patient