FINANCIAL POLICY

Thank you for choosing the Cheyenne Eye Clinic and Surgery Center for your eye care needs. This patient financial policy and consent form has been developed to assist in answering your questions regarding patient and insurance responsibility for services rendered. Your understanding of and compliance with our patient financial policy is important. Please read the policy below and ask the staff any questions you may have and sign as indicated. The original will be maintained in your file and a copy may be provided to you upon your request.

INSURANCE POLICY

Your insurance policy is a contract between you and your insurance carrier. You are responsible for providing our practice with the correct insurance information at the time of service or you may be responsible for the charges in full. Should your insurance company fail to pay for services rendered by Cheyenne Eye Clinic and Surgical Center, you will be responsible for the bill. Therefore, we recommend that you follow-up with the insurance carrier if your claim has not been paid within 30 days from the date the services were rendered.

ASSIGNMENT OF BENEFITS

Payment of authorized Medicare, Medicaid or applicable private insurance benefits will be paid directly to Cheyenne Eye Clinic and Surgery Center for services provided by Cheyenne Eye Clinic and Surgery Center physicians and employees.

CO-PAYMENTS, DEDUCTIBLES, & CO-INSURANCE

Patients are expected to pay AT THE TIME OF SERVICE all amounts that are not covered by their insurance company. These amounts include co-payments, co-insurance, and/or deductibles. Payments may be made by cash, check, and/or credit card (MasterCard, Visa, and Discover).

1. If the deductible is not met, a $100 deposit at the time of service will be collected. Once the insurance has been billed, any balance is the patient's responsibility.

2. Patients who are unable to pay their co-pays and/or non-covered charges at the time of service may be asked to reschedule their visit.

REFRACTION

Refraction is the measurement of the focus error of an eye. It determines the set of lenses that will best focus the light entering the eye. The results of a refraction are used to: (a) determine the health and visual potential of an eye; (b) aid in performing tests such as visual fields; and (c) to prescribe glasses and/or contact lenses.

- Refraction is considered a "non-medical" service by most insurance companies and is therefore most usually a non-covered service. Starting January 1, 2017, the REFRACTION FEE is $40.00 and is due at time of service, if performed as part of the patient's examination.

OPTICAL

Before an order for optical goods can be placed, no less than a 50% deposit must be made. Optical goods cannot be dispensed until the goods are paid in full.

REFERRALS

Some patients will be required by their insurance company to obtain a "referral" from their Primary Care Physician authorizing their visit to the Cheyenne Eye Clinic and Surgery Center. It is the patient's responsibility to obtain this referral and to be sure that the referral is communicated to the Cheyenne Eye Clinic and Surgery Center before the patient's visit.

1 A patient presenting at the Cheyenne Eye Clinic and Surgery Center without a required referral will be asked to sign a waiver by which he/she agrees to pay all charges generated by the visit, if a referral is not obtained to cover the visit. The patient will also be expected to pay a $100.00 deposit at registration for their office visit and any additional charges at the end of their visit.

2 If a referral is ultimately received for the visit and if the insurance pays, a refund will be sent to the patient reflecting the insurance payment.

3 Patients are reminded that many physician offices will not provide a retroactive referral.

4 Patients presenting without a required referral and who do not agree to sign a waiver and are unable to pay at least the $100.00 deposit may be asked to reschedule their appointment(s).

BILLING OFFICE

Patients who are experiencing difficulty in making payments on open accounts are asked to contact a Patient Account Representative at (307) 773-7150 in order to establish a fair and appropriate payment plan. Patients may be asked, in these circumstances, to provide financial income information which can be used to determine an appropriate and fair monthly payment.

SELF-PAY PATIENTS

Self-pay patients (i.e., patients with no health insurance) will be expected to pay a $100.00 deposit at check in for their office visit. The final bill will be calculated at check out. Any additional fees will be collected or overpayment refunded, upon checking out. Payment in full is expected on the date of service.

OPEN BALANCES

Patients with open balances on previous office visits or surgical procedures who are not current on payments (behind on their payment contract) will be asked to make a payment on their account before additional services are rendered. Patients who are unable to make a payment may be asked to reschedule their visit. Exceptions to this are under the discretion of the Billing Department, the Office Manager, and/ or the Doctor. Please phone the Billing Department if you have questions about your account and/ or to make payment arrangements. We are here to care for you and your eyes, and want to work with you to meet your needs.

COLLECTION FEES

Patient accounts which have not been paid by the patient and/or insurance for 90 or more days since the office visit may be referred to a collection agency or attorney for collection. The patient agrees to pay costs, which could include reasonable attorney fees, court filing fees or other reasonable costs of collection efforts, in addition to the account balance.

MISSED CLINIC APPOINTMENTS

Please help us serve you better by keeping scheduled appointments. In the event you are unable to keep your scheduled appointment, please give a 24-hour notice. Due to the increased demand for appointment times and having long waiting lists for cancellations, it has become necessary to implement a Late Cancellation/ No Show policy for office visits and surgery.

24 Hour notice is required for all cancellations.

If a patient frequently fails to keep appointments a fee of $50 will be assessed to the patient's account and may ultimately result in dismissal from our practice.

This charge is the responsibility of the patient and will not be submitted to any insurance carrier.

RETURNED CHECKS

There will be a $35 fee assessed to your account for any check returned to our bank as unable to process for any reason.

FINANCIAL POLICY AGREEMENT

- I understand that I am financially responsible for and agree to pay all of the charges that are not paid by insurance or any other third party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable insurance copays, coinsurances, and deductibles today. If you are unable to verify my insurance at time of service, I will pay in full for all services.

- I understand that Cheyenne Eye Clinic and Surgery Center will file my insurance claims as a courtesy; however, I am ultimately responsible for full payment of all charges not covered by insurance(s). Should collection proceedings or other legal action become necessary to collect an overdue account, I understand that the Cheyenne Eye Clinic and Surgery Center has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered.

- **I understand that if my deductible has not been met at the time of service, I will be required to pay $100 deposit at time of service. Once my insurance has been billed, any balance will be my responsibility.**

- I understand that I am responsible for my entire visit if I have no insurance and will be considered Self-Pay. I am required to pay a $100 deposit upon arrival and any additional amount that may be due, at check-out.

Signed: ____ Date: ______________________

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