ADAIRSVILLE EYE ASSOCIATES

OUR FEES AND OUR PAYMENT POLICIES

We are here to provide you with the eye care you need. We have established fees that enable us to have the quality staff and facilities that are necessary to provide the care you expect. This explanation of our payment policies has been prepared so that you can help us maintain quality services. Like you, we are concerned about the cost of health care. Our payment policies are designed to enable us to reduce unnecessary collection costs that would otherwise increase the cost to our patients.

YOUR RESPONSIBILITIES FOR CHARGES

You are ultimately responsible for the payment of charges for services you receive. If payment is to be made through an insurance or medical plan and we have agreed to accept assignment from that plan, then you are responsible for complying with all procedures required by that plan to enable us to receive payment on your behalf. **To assure that your insurance or medical plans will provide covered benefits, you must let us know at the time you schedule your appointment and when you check in, how you plan to provide payment for your visit.**

If you will be paying personally for services or if you are responsible for a deductible or co-payment, we expect payment at the time service is rendered. We accept cash, personal checks, VISA, MASTERCARD, and DISCOVER. If your are experiencing personal circumstances that will make the payment of our charges difficult for you, please ask to speak with our office manager prior to seeing the doctor.

MEDICAL AND SUPPLEMENTAL PLANS

We accept assignment for Medicare and will file supplemental insurance claims for those plans that accept a claim directly from Medicare. If your supplemental plan does not accept a claim directly from Medicare, you must pay the co-payment to us and file a claim to your plan after you receive your EOB (Explanation of Benefits) from Medicare. A refraction, which is part of an eye examination, is **not** a covered service under Medicare and payment is your responsibility.

INSURANCE PLANS

We will generally file insurance for you. We do expect you to make prompt payment for any portion that the insurance company will not be responsible. Our business office personnel will discuss payment arrangements with you appropriate to your circumstances. **For office services, we expect payment from you at the time service are rendered. We will provide you with a receipt that will enable you to file a claim with your insurance company for covered services.**

OTHER QUESTONS

Our primary concern is that you receive the eye care you need. Your understanding of our fees and payment policies and your cooperation with our procedures will enable us to provide more satisfactory service to you. Should you have any questions regarding these matters, please speak with one of our office staff.

Thank you for selecting us for your eye care needs.

PATIENT ACKNOWLEDGEMENT

I have read and understand the policies explainged above. I understand that my compliance with thes policies will facilitate my care and help to hold down the cost of health care. I agree to pay, at the time services are rendered, for charges for which I will be personally responsible and to provide accurate and timely information to assist Adairsville Eye Associates to obtain payments from any medical plans in which I participate.

ASSIGNMENTS AND MEDICAL RELEASE AUTHORIZATION

I authorize payment directly to Adairsville Eye Associates for charges for eye care services rendered to me and otherwise payable to me for those services for which Adairsville Eye Associates accepts assignment. Any non-assignable benefits payable to me are to be remitted by check payable jointly to the undersigned and Adairsville Eye Associates. I authorize any holder of medical or other necessary information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agents of my insurance companies, or medical care plans, or the my employer if this is a Worker's Compensation claim, any information needed to determine benefits or make payments for this or a related insurance, Medicare or other medical benefits claim. I permit a copy of this authorization to be used in place of the original.

INSURANCE

Are you a participant of Medicare? Yes_____ No_____
Are you a participant of Medicaid? Yes_____ No_____

I hereby authorize payment directly to Adairsville Eye Associates, for service rendered otherwise payable to me to cover medical charges, including major medical. Any non-assignable benefits payable to the undersigned are to be remitted by check payble jointly to the undersigned and Adairsville Eye Associates. I understand that I am financially responsible to Adairsville Eye Associates for the charges and other fees not covered by this assignment. **This office will assess any 18% annual finance charge, 1.5% monthly, on all accounts with balances over 90 days that are patient responsible.**

_____ _____
Patient's or Responsible Party's Signature Date Signed

_____ _____
Patient's Name (PLEASE PRINT) Responsible Party if Patient is a Minor or Incapacitated