SOUTHPOINT EYE CARE, P.C.

FINANCIAL POLICY

ALL PATIENT'S PLEASE READ THIS PAGE FULLY-THANK YOU

Basic Policy: Payment for services not covered or filed to insurance is due in full at time of service.
Insurance: Southpoint Eye Care will bill most insurance carriers for you if proper paperwork/information is provided to us. We will bill most secondary insurance companies. Copayments and deductibles are due at time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why is paid less than the anticipated for care. If an insurance carrier has not paid with **60** days of billing, professional fees are due and payable in full by you. You may seek reimbursement from your insurance carrier. All referrals are the responsibility of the insured.

Medicaid/Peach Care: All Medicaid patients must show a valid ID card at each visit.

Medicare: We will bill Medicare and any secondary insurance carriers for you. All coinsurance and deductibles are due at time of service.
Surgical Fees: All co-pays, coinsurances, deductibles, or payments are due prior to surgery. Your carrier may require prior authorization which we will obtain for you. We require a (**2**) day notification to cancel any out-patient surgical procedures, otherwise accounts will be billed a **$50** cancellation fee for each occurrence.

Non-Covered Services: Any care not covered by your insurance carrier will require payment at the time of service or upon notice of insurance denial.
Personal Injury Cases: Southpoint Eye Care does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment at the time of services.
Worker's Compensation Claims: If your injury is work related, we will need the case number, claims mailing address, carrier name, and phone number. Authorization for treatment is required from a company supervisor/responsible party on company letterhead. Any claims denied or not paid by your employer or worker's compensation carrier become the responsibility of the patient. The patient may then seek reimbursement from the carrier.
Missed Appointments: In fairness to all patients and the office, we require at least a **24** hour notice to cancel. If no notification is given, accounts will be accessed a **$50** no show fee.
Medical Records: Request for medical records require a **(5) business** day notification so that we may review and copy records for you. A fee of **$20** is due at time of pickup.
Medical forms completions: Request for form completions requires a (5) business day notification. A fee of **$20** is due at time of pick up.

<u>**All patients/legal guardians, please sign below.****</u>**

I have read, understand, and agree to the above financial policy for payment of professional fees.

I request that payment of authorized benefits be made to Southpoint Eye Care, P.C. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine thee benefits or the benefits.

Date: ______________________________ Signature: ________________________

I hereby authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for any health care related utilization review or quality assurance activities or any healthcare professional requiring this information.

I hereby assign and authorize payment to Southpoint Eye Care, .C. of all medical and/or surgical benefits, including major medical policies, to which I am entitled to under any insurance policy or policies, under any self-insurance program, or under any benefit plan.

I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including but not limited to, payment of those fees and charges not directly reimburse to Southpoint Eye care, P.C. by any insurance policy, self-insurance program or other benefit plan.

Additionally, I understand and agree to pay any and all collections cost and/or attorney's fees if any delinquent is placed with an agency or attorney for collections, suit, or other legal action. All outstanding balance will be subject to a finance charge equal to 1.5% monthly, as well as a monthly re-filing charge of $10.00 a month.

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

Patient Signature: ____
Person Providing the Authorization: _________________________________
Relationship to patient if not patient: _________________________________

Date: ________________________________