FINANCIAL POLICY

Thank you for choosing **Eye Care & Surgeons of Charlotte (ECS)** for your healthcare needs. This policy is designed to provide you with a clear and concise understanding of your financial responsibilities with regards to any service rendered. It is the policy of ECS that payment in full is due at the time of service unless special arrangements have been made in advance. This includes co-payments and/or deductibles that are required by your insurance company.

Filing Insurance

I understand ECS will file claims on my behalf to insurance companies that ECS is contracted with. If ECS is not contracted with my insurance company, I agree to pay for services in full the date services are performed. ECS will be happy to assist me in filing my claim with my insurance company. I understand that ECS will bill me for any remaining portion of my balance, if any, once all insurance claims have been made and payments have been received. I understand that I am financially responsible for services deemed to be not medically necessary or for services not covered by my insurance plan. I am also financially responsible for any Deductible, Coinsurance or Co-payments that result from any claims that are filed. ****Copayments are due at the time services are rendered.** **

Refractions: A **refraction** is the part of the exam by which we determine whether you can be helped in any way by a new glasses prescription. It is also how we determine the best possible visual acuity and function of your eye, which is essential medical information for our providers as they assess your eyes. It is NOT a covered service by most medical insurance companies. **Our refraction fee is collected upon check-out from your visit.** If your insurance company pays for your refraction, we will reimburse you accordingly.

Self- Pay (no insurance/non-participating plans)

I understand that should I not have insurance coverage for the services rendered, or if the insurance information I provide to ECS be inaccurate, or should coverage not be in effect at the time of service, I will be responsible for payment in full for services rendered at the time of service. I understand that I will be required to make pre-payment for services prior to being seen by the provider, and at check-out, I will be responsible for any fees over this pre-payment amount. I understand that if the services rendered cost less than the pre-payment amount, I will be refunded the difference via separate check.

Returned Checks

I understand that ECS will charge me $35.00 for any returned check or insufficient funds denial. I understand that payment in full (amount of total charge + $35.00 fee) is due ten (10) calendar days after ECS contacts me regarding the returned/insufficient check. Payment in full as a result of returned/insufficient checks may be paid in cash, money order or credit card only. ECS will not accept a check to cover payment for a returned check.

Account Balances

I understand after my insurance has paid and/or processed my visit, there may be a balance remaining. ECS will mail a statement showing the patient responsibility. I understand that I must pay any outstanding balance due within the time frame shown on the statement. I understand that any outstanding balance must be paid upon arrival for my next appointment prior to additional services being rendered, unless I have been approved for a payment plan by ECS. I understand that failure to pay any outstanding account balance may result in my account being forwarded to other agencies for collections and to credit reporting agencies.

I certify that I have read the above conditions of treatment. I understand and agree to their content.

_____ _____

Signature of Patient or Patient's Authorized Representative Date

_____

Printed Name of Patient

Description of Personal Representative's Authority (attach necessary documentation)