Walla Walla Eye Center Financial Policy

Thank you for choosing the Walla Walla Eye Center for your care. Our goal is to provide you with the highest quality medical services. We want to tell you our policy regarding billing and payment. Please read this statement carefully and sign below. We will be happy to answer any questions you may have about this policy.

Patients are financially responsible for services they receive. We contract with many but not all insurance companies and plans. Patients are responsible for verifying whether or not our practice is contracted with your plan. Patients are responsible for obtaining any authorization your insurance carrier requires for your services. Please check your Insurance Handbook, website or contact your Insurance Company directly. Taking a copy of your insurance card or accepting a co-pay from you, does **NOT** mean we accept payment at a contracted rate. ***All charges are ultimately the patient's personal responsibility.***

Deductibles. Many insurance policies have a deductible amount that must be paid for by the patient ***before*** the insurance company will pay a benefit. Patients are responsible for all deductible payments and patient balances that remain after the insurance company has responded to the charges associated with your service date. We cannot "write off" amounts that are not covered by your deductibles. ***All accounts that are 90 days past due are turned over to the PSB collections agency.***

We need your most current insurance information. We are happy to bill your insurance for services you have received while at The Walla Walla Eye Center. To do this, we need a copy of your most current Insurance card or coupon.

Your co-pay must be paid at the time of your visit. Your Insurance Company mandates that we collect co-payments at the time of your visit. If the co-pay is not paid at the time of visit we will send a bill to you with an *additional charge of up to $10.00* due to the cost of sending statements.

We are pleased to see patients without insurance, but if you do not have insurance, you will be required to pay a deposit before your exam. Deposit fees might be postponed in the event you are referred from the Emergency Department of the hospital. Patients are responsible for services incurred for emergency visits. If you pay your bill in full on the date of service you will receive a 10% discount. We accept credit cards. If this presents a hardship for you, please call our office *at least 24 hours before your scheduled appointment* and ask to speak with our billing supervisor to discuss payment options.

There is a service fee for returned checks. If your check is returned by the bank for non-sufficient funds, we will charge an additional $30 dollars to your account. You will be required to pay the amount of the bad check plus the service charge with **cash or money order within 10 days.** If we do not receive payment within 10 days, we will flag you account and begin an internal debt collection process. In the future we will no longer be able to accept checks from you.

We expect you to keep you account current. We charge a $10 monthly service fee on account balances that are not paid within 30 days after your insurance responds to us. If you are unable to make a payment, you must contact our Business Office. ***All accounts past due for 90 days are sent to a professional collection agency.***

We assess a $50 charge to NO SHOW appointments. If you are unable to keep an appointment, it is important to give us **at least 24 hours notice** so that we may give that time to someone else.

Services not Covered by Insurance: Optical hardware, contact lenses , refractions and screening photos are not always covered by insurance. Please check with your company for your coverage options. ***Fundus screening exams are a $40 charge.***

HIPPA Acknowledgement: I understand that this office has a privacy policy in place and I have had an opportunity to review this policy. I understand that I may have a copy of this policy at any time.

My signature below indicates that I have read and fully understand the Walla Walla Eye Center Financial Policy and agree to all the terms set forth.

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Signature of Responsible Party Date