Envision
Eye Specialists | PC

1011 Bowles Avenue, Suite 200 Fenton, MO 63026
1390 West Liberty Street, Farmington, MO 63640

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Envision Eye Specialists as your healthcare provider. We are committed to providing you with the best possible care, your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

APPOINTMENTS – 24 hours notice must be provided in the event you cannot keep an appointment. Should you not provide this notice, a cancellation fee of **$25.00** may be added to your account. A cancellation fee of **$200.00** may apply for cancellation of Premium Surgical Services.

REFERRALS – If your plan requires a referral from your primary care physician, it is your responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, you will be requested to sign a financial waiver. It is then your responsibility to provide us with the referral within 48 hours (about 2 days) or you will be personally responsible for that day's service.

CO-PAYMENTS – By law we must collect your carrier designed co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay on each visit. Should you not pay at the time of service, and we subsequently send you a statement, an administrative fee of **$5.00** may be added to your account. Any procedure performed in this office could be deemed surgical by your insurance company and all co-pays and deductibles will apply.

FMLA AND/OR WORKER'S COMPENSATION – There is a $25.00 charge for completion of FMLA or Worker's Compensation Forms.

SURGERY DEPOSITS – If you and your physician determine that your course of care requires surgery, a surgical deposit will be collected at the time of scheduling. Our scheduling coordinators will work with you to determine estimated insurance payment and estimated patient responsibility.

OUT OF NETWORK PLANS – You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-insurance and deductibles. If we do not "participate" with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days (about 1 and a half months), you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to the physician's office.

Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to Envision Eye Specialists, PC for any services furnished. I understand that I am fully responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or the agent) information concerning healthcare, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

SELF-PAY PATIENTS – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

MEDICARE – We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to your secondary insurance if you have one.

Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits to be made on my behalf to Envision Eye Specialists, PC for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for any related services. This information will be used for the purpose of evaluation and administering claims of benefits.

DIVORCED / SEPARATED PARENTS OF MINOR PATIENTS – The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Envision Eye Specialists, PC will not be involved with separation or divorce disputes.

INSUFFICIENT FUND CHECKS – A $25.00 fee will be charged to the patient's account for checks returned due to non-sufficient funds.

You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be additionally responsible for whatever charges we incur because of this.

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, DISCOVER, CARE CREDIT OR WELLS FARGO. THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

Patient's Name: _____ DOB: _____

Responsible Party Signature: _____ Date: _____