FINANCIAL POLICIES AND PROCEDURES

At Advanced Cataract & Glaucoma Care, PLLC, we believe that all patients who are rendered care at this office deserve the best medical care that can be provided. We provide you with this Agreement regarding our financial policy and your agreement to pay for services provided so that you are aware of our policies and procedures up front. We require each patient to sign and date this Agreement on the last page to indicate you accept these terms.

PAYMENT AT TIME OF SERVICE, FEES, AND COLLECTIONS

Your insurance policy is a contract between you and your insurance company. We do provide your insurance carrier with information regarding your diagnosis and treatment. We do not get involved in such matters as disputes regarding deductibles, copayments, non-covered charges, and "usual and customary" charges**. If your insurance carrier does not provide payment within 45 days after treatment, you will be responsible for payment. You are responsible for timely payment on any balance on your account. We require that you pay any amount not covered by your insurance such as deductibles and copayments under your policy on the day of service.** If your plan requires you to pay coinsurance, you will be required to pay it. Advanced Cataract & Glaucoma Care, PLLC is required, in accordance with its contract with your insurer, to collect from you deductibles and copayments at the time of service. We will determine your copay and how much of your yearly deductible under your policy has been met for the year, if possible. Ultimately, you are responsible for knowing this information. If you are unable to pay your copayment at check-in, another appointment will be made for you. We would be in breach of our contract with your insurance if we allow services to be rendered having not collected your copay. Account balances must also have a monthly payment plan in place and any monthly payment not received by the date of your scheduled appointment will be required to be paid prior to seeing a provider. We will always work with you to arrange a payment plan.

We will request to see your current insurance card and photo identification at every visit so that we may verify insurance accurately which will allow us to properly bill the insurance company in a timely fashion. It will be reviewed or copied every time you are here for a visit, no matter how frequently you are seen. It is your responsibility to ensure you provide us a valid and correct insurance card at each visit. If a claim is rejected because your insurance does not cover the type of service rendered or if you provided us an expired insurance card, you will be held financially responsible for payment of services and any outstanding balance. Please call the telephone number on your insurance card before your appointment and they will assist you in finding out whether the service to be provided at the appointment is covered, whether a referral or prior authorization is required, and what your copay and deductible is. It is your responsibility to understand your insurance coverage. If your insurance does not cover the cost of the visit or procedure, you will be responsible for all services and charges.

Please educate yourself as to your coverage so that office visits, procedures, testing, and specialist referrals may be arranged to best suit your needs.

Once we determine your personal financial obligation or after your insurance company reimburses Advanced Cataract & Glaucoma Care, PLLC, for a portion of your care, we may mail you a statement. Payment is expected upon receipt of the first statement**. Any account past due by 30 days or more may be subject to submission to our collection agency or a claim will be filed in court.** If your account

becomes delinquent and is placed into our collection or court process, all collection fees and court and attorney fees will be your responsibility and added to your balance. Advanced Cataract & Glaucoma Care, PLLC reserves the right to discharge, with proper notice, any patient for non-payment. By signing our financial policy, you agree to pay these added fees, along with any and all costs associated with the collection of your account, including interest charges.

If a new problem is encountered, or if changes in treatment of a pre-existing condition are discussed in the process of performing a visit or exam, an additional copay and deductible payment may be incurred. This is your insurance company's policy, not Advanced Cataract & Glaucoma Care, PLLC's.

If you are seen in our office by a nurse or a medical assistant for minor medical services you may be charged a limited office visit, and applicable co-pays will be collected as required by your and our contract with your insurance.

If you obtain services or consultations through phone calls, Online Digital Services or telehealth (for example Virtual Check-In, E-Visits and Telemedicine, or Evaluation of Video or Images), you may be charged for these services, and applicable co-pays will be collected as required by your and our contract with your insurance.

If you carry a balance on your account during the time you present to our office, a payment on your account will be required at the time of service unless a prior payment plan has been set up. We accept cash, check, debit, or credit card. Failure to pay these at the time of service will result in your appointment being rescheduled. Under unusual circumstances, we are willing to work out a minimized personalized payment schedule (that will not exceed 4 months) if you so require and can demonstrate need. For payment plans, Advanced Cataract & Glaucoma Care, PLLC requires the patient to provide a credit or debit card to be kept on file to ensure a payment plan is in place for account balances. We do not make exceptions to this policy.

COPAYS AND DEDUCTIBLES

Copays and deductibles may be required by your insurance plan. This is a contract between you and your insurance. We also have contracts with your insurance, and we are required to collect these at each visit. **We will not waive any copay or deductible, as this is in violation of your and our contract with your insurance, so please do not ask us to do so.** Failure to pay these at the time of service will result in your appointment being rescheduled.

CREDIT/DEBIT CARD ON FILE

Statements are wasteful of paper, stamps, and envelopes, and are not an efficient way to run a medical practice. We need to ensure that we have a guarantee of payment on file in our office. With higher co-pays and deductibles, we need to be sure that patient responsible balances are paid in a timely manner. **We encourage patients to keep a credit or debit card on file. We have wonderful patients and we know that most of you pay your balances. Unfortunately, this is not the case every time. If you have a card on file, you will no longer regularly receive repeat bills from our office in the mail – if you have a card on file, your card will be charged after the first billing is sent.**

You will receive communication in the mail from your insurance carrier that explains how much of your office visit they pay and how much you pay. This is called an Explanation of Benefits, or EOB. This communication tells you exactly, according to your health insurance coverage, how much of your health care bill is your responsibility and how much is the responsibility of your insurance company. We receive the same communication that you do. It arrives 10-30 days after your insurance has processed your claim. We look at each Explanation of Benefits (EOB) carefully and determine what your insurance has determined as patient responsibility.

We do not store your sensitive credit card information in our office. We store it in a secure fashion with a reputable financial firm called a gateway. We access your information only on this site to process a payment. You will be required to sign a credit card on file authorization statement that will allow us to charge an amount agreeable to each of us until your balance is paid in full.

We will always work with you to understand if there has been a mistake, and we will refund you if we have made a billing error. We will only charge the amount that we are instructed to by your insurance carrier.

ELECTIVE PROCEDURES/NON-COVERED PROCEDURES

Patients are required to pay the estimated self-pay portion of elective/non-covered procedures prior to services being rendered based on insurance verification and eligibility of benefits.

SUBMISSION OF CLAIMS

We will submit your insurance claims on your behalf to your insurance company. However, it is important to remember that your insurance is a contract between you and your insurer. Although we file insurance claims as a courtesy to you, you are still responsible for payment of services regardless of the amount your insurance pays.

PAYMENT OPTIONS

Our office accepts most credit and debit cards. Our office also accepts valid checks or cash. **There will be a $50 fee for all returned checks.** Once we have a returned check for you, we may require that all future payments be with cash, money order, or cashier's check or credit card. Anytime a co-pay, deductible, or balance is due, we will charge the fee to your credit or debit card on file which will help to keep you at a zero balance and paid in full with your credit or debit card on file.

CASH PAYMENT

If you wish to pay cash, YOU WILL ALWAYS BE PROVIDED A RECEIPT so that you will have record of your payment. Please make us aware if you are not provided a receipt at any visit.

MEDICARE PATIENTS

If you have Medicare as your primary insurance carrier, but you do not have a secondary insurance, you are responsible for the deductible, co-pay, and co-insurance at the time of service. You are also responsible to pay for services not covered by your Medicare insurance unless you have a secondary insurance that covers this charge. You will be required to sign an Advanced Beneficiary Notice for non-covered services.

NON-CONTRACTED INSURANCE (Out of Network)

If you have an insurance plan that we do not participate with, you may or may not have out-of-network benefits. These benefits typically have a higher co-pay, coinsurance, and/or deductible out of pocket cost. You will be considered a self-pay, uninsured patient if you DO NOT have out of network benefits and if your insurance does not pay for the service, you are financially responsible.

Please understand that what your non-contracted insurance deems "allowable" may not cover the entire charge and you would be responsible for that difference as well.

UNINSURED/SELF-PAY

We offer a discount to all self-pay patients who pay in full at the time of service. Payment is expected at each visit. All other ancillary, treatment, and future care will be reviewed with you in order to plan for payment**. We require a $75 non-refundable deposit be put down to schedule your first, initial visit with us which will then be used towards the total cost of that first visit.** This will serve as the no-show fee if that occurs.

MISSED APPOINTMENTS/NO SHOWS/LATE FOR APPOINTMENT

We understand you may not be able to keep all of your scheduled appointments or might occasionally be late. Please understand that missed appointments have a detrimental impact on our practice and other patients. They also affect our ability to serve other patients in need of medical care. We understand there may be inclement weather or other circumstances that may require you to cancel your appointment**. If you must cancel or re-schedule your appointment, please do so at least 24 hours in advance. Failure to cancel or reschedule an appointment at least 24 hours in advance, or arriving more than 15 minutes late, will be considered a no-show. If you have 1 no-show appointment where you did not notify us in advance, we will require you to pay a fee to hold your future appointments on the schedule in the amount of $75.** When you present for your appointment, the $75 fee will be credited to your co-pay and any credit card balance will be kept in your account for future account balances or we will send the credit balance to you in the form of a check. **Advanced Cataract & Glaucoma Care, PLLC reserves the right to terminate any patient with more than one no-show appointment upon 30 days written notice to the patient to seek medical help from another practice.**

If you are running late on the day of your appointment due to unforeseen circumstances, please contact our office immediately so that we can determine whether we can see you that day or if we will need to reschedule your appointment. **If you are more than 15 minutes late for an appointment, you will be**

considered a no-show appointment and Advanced Cataract & Glaucoma Care, PLLC may reschedule your appointment and refuse to see you at the originally scheduled time.

REFERRALS

If your insurance carrier requires a referral or authorization for your visit, it is your responsibility to make sure that our office receives the current valid authorization. If you do not have a valid referral or authorization at the time of service we will be unable to treat you until a valid referral or authorization obtained, and you may be sent back to your primary care physician to obtain authorization prior to being treated or full payment from you will be expected at the time of service. Please remember that it is your responsibility to make sure we are on your plan's provider directory. We appreciate your understanding of the ever-changing requirements of managed care plans and our position to adhere to their policies or requirements.

REFRACTIONS **INITIAL _____**

What is this? This determines your need for lenses to correct your refractive error, also referred to as your refraction, or your eyeglass prescription. This is the part of the exam where the doctor, or other staff member flips various lenses inside the phoropter and asks questions like "Better 1 or Better 2?". We keep asking these questions until we have helped you achieve the best possible vision. This will typically be performed if there is a change in vision, a comprehensive exam, a cataract evaluation, or if we are asked if the glasses need changed.

Why do I have to pay for it? CMS, the department of the federal government that controls Medicare and Medicaid, has decided that refractions are not a payable part of an eye exam. CMS, directly under control of the US Congress, has determined this is a "noncovered" service. That means you have to pay for that portion of the eye exam. Further, CMS has declared that if we don't charge you extra for this service, we could receive various forms of punishment. This has been enforced since about 2007. Our fee is $45 for a refraction.

Why don't we tell you about it during the exam? Many of our colleagues have stopped the exam to say "this part is not covered by insurance – you have to pay for this." The feedback they received from patients was not pleasant. Most of our patients would be disappointed if we completed the exam without receiving a prescription, so we just proceed, unless you tell us to stop.

PRIOR AUTHORIZATIONS

We do not complete or submit prior authorizations for generic medications nor surgery medications, so please fill these as soon as possible at your pharmacy.

OTHER FORMS

- FMLA, Disability, Corps, School forms not completed during an appointment, and supplemental insurance forms $50.
- Dictated letters, extensive forms with review of medical records $50
- Copies of records for personal use will be charged the allowed fee by the State of Florida.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Advanced Cataract & Glaucoma Care, PLLC: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for all services provided to me by Advanced Cataract & Glaucoma Care, PLLC. This order will remain in effect until revoked by me in writing.

I have received the practice's Medical Authorization for Release/Disclosure of Protected Health Information/HIPAA Privacy Notice.

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider and legal or administrative claim or chose an action arising under any group health plan, employee benefit plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including and right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or medications provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit notice of appeal proceedings; (3) make statements about facts or laws; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party. Insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked in writing, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare, and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULL UNDERSTAND THIS AGREEMENT.

Name (Print):	**Date**

Signature **Name of Person Financially Responsible for Patient's Treatment (PRINT):**	**Date**