Financial Policies and Patient Payment Agreement

Alaska Eye Care Centers is committed to providing our patients with the best possible optometric care and minimizing healthcare costs. Our prices are reflective of the usual and customary charges for our area. The following policy statement and financial agreement outlines the patient's and the practice's financial responsibilities concerning payment for services:

1. Our Optometrists are preferred providers for **Medicare, Medicaid, Aetna, Blue Cross, Cigna, VSP, and Davis Vision** insurance plans. Our billing office will submit a claim for services rendered for patients that are members of one of these plans. However, the patient must first provide us with their insurance cards and complete all necessary insurance information, including any special forms, before leaving the office in order for our billing office to submit a claim on behalf of a patient.
2. We do not accept or bill the following insurances **Tricare, Eyemed, Champus, Avesis Claim, Optum Health, Spectera, Vision One, ECPA, UHC Vision, Coast to Coast, Cole Vision**. We will provide you with a copy of your fee slip in order for you to submit to your insurance and be re-imbursed directly. Payment in full is expected at time of service.
3. **It is the patient's responsibility to pay all co-payments at time of service as specified by their insurance plan.** If a patient operates under a self-pay system, payment in full is expected at time of service.
4. It is the patient's responsibility to pay all deductible, co-insurance and/or non-covered services within sixty (60) days after insurance has processed your claim and identified your portion.
5. **We accept cash, personal checks, debit card, MasterCard, Visa, and Discover and HFS cards for payment of all services.**
6. Payment plan options are offered for large patient balances. Please contact our billing specialist to set up a payment plan. Co-payments and amount due for non-covered services (including deductible) will be expected at the time of service. We will not bill discounted services to insurance.
7. **Refraction Fee:** The refraction is part of the eye exam that the doctor determines your prescription that gives you the best vision. Federal guidelines require that the eye exam and the refraction are billed separately. Some insurances **(Medicare)** do not pay for the refraction. You may be responsible for payment of this service.
8. **Refund Policy:** For any refund owed to patient after insurances have paid, we do so in the same manner as payment is received. If payment is made by cash or check, Alaska Eye Care Centers will refund by check in the mail directly to patient or guardian. Our Accountant does refunds at the beginning of the month
9. Due to strict timely filing requirements, it is the patient's responsibility to provide our office with active insurance information at the time service is provided. Our practice will verify vision insurance for vision services. Please be aware that if active insurance information is not provided, the patient will be liable for all services denied coverage because timely filing requirements have not been met.
10. Payment of claims can be delayed. Insurance companies may require additional information from the patient and/or your Optometrist. Patients are responsible for completing all insurance requests promptly and notifying the practice when the requested information has been sent in the event a claim needs to be re-filed or further information is needed.
11. The patient is responsible for making payment even if they are disputing the claim with their insurance company.
12. When a parent or legal guardian signs paperwork for minor child or dependent, they are the party initiating treatment, and will be financially responsible for the account
13. Our staff is happy to help with insurance questions relating to how a claim was filed, or regarding any additional information the carrier might need to process the claim. Specific coverage issues, however, can only be addressed by the patient's insurance member services department. (Please see the number provided on your insurance card.)
14. Please note that in conformance with HIPAA regulations, Alaska Eye Care Centers will not disclose any protected health information, including financial information, without your authorization, except as described in our Notice of Privacy Practices.
15. **I understand that in the event any unpaid balance (over 90 days past due) will be placed in collections with Cornerstone Credit Services (CCS). You will be responsible for any fees/interest charged by CCS. Unpaid balances on your account need to be paid in full before you can be seen again. Please be aware that the signer's failure to pay as specified in this agreement, and if your patient balance remains unpaid, you may be discharged as a patient from our practice.**

16. **Patient Insurance Signature on File:** I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I request that payment be made on my behalf to **Alaska Eye Care Centers, APC** for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage, my signature authorizes release of the above medical information to the insurer or agency shown, and authorize my doctor to act as my agent, as above.
17. Once a claim gets billed to the insurance our policy is that we cannot change the primary diagnosis code.
18. **Restocking Fee:** If a frame and/or lens order is returned within 30 days from pickup, the patient is responsible for 30% of total cost of order.
19. **Cancellation Fee:** If a frame and/or lens order is canceled, the patient is responsible for 50% of the balance owed by the patient.

Please sign below to indicate that you have read, understood and will comply with Alaska Eye Care Centers financial policies and your obligations as indicated above. This form is valid for 1 year from date signed.

☐ I have read and understand the above

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Patient Name (Print)

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Signature of Patient/Responsible Party

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Print Name of Guardian/Responsible Party (if MINOR)

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Date