FINANCIAL POLICY

Columbia Eye and Columbia Eye Surgery Center's financial policy is designed to ensure transparency and understanding regarding our billing practices and your financial responsibilities as a patient. The physicians and staff of Columbia Eye and Columbia Eye Surgery Center are dedicated to providing you with the best possible care and service. Understanding our financial policies is an essential element of your care and treatment. Below is a detailed overview of our policy.

Financial Policy Overview

- Upon each visit, patients are required to present their insurance card and a valid form of identification.
- Full payment of co-payments, co-insurance, deductibles, and services not covered by insurance, such as refractions, contact lenses, eyeglasses, and over-the-counter products, is due at the time of service or upon product pickup.
- We accept payments via cash, check, and credit card (Visa, Mastercard, Discover, and American Express).
- Our clinic selectively participates in vision plans. Patients intending to utilize vision benefits should verify participation with their vision plan before scheduling an appointment.

Insurance Policies

- By providing us with your insurance details, you acknowledge your responsibility to pay for all services rendered. Your insurance contract is between you and your insurer; thus, understanding your coverage is imperative. It is your responsibility to notify us of any insurance changes.
- We contract with many medical insurance health plans and will submit claims for services rendered to those we have agreements with, collecting any necessary copayment, coinsurance, and deductibles at the time of service. Services deemed not covered or visits with incorrect insurance information provided will incur charges payable in full by the patient.
- For any insurance plan that requires referral or authorization, it is the patient's responsibility to obtain this information from their primary care provider before their appointment. Failure to obtain a referral or authorization will result in the cancellation of an appointment.

Refraction Fee

- A fee of $40.00 is applicable for refractions conducted during an exam, payable at the time of service. Typically, medical insurance plans do not pay for the refraction part of your eye examination. Eye refractions are necessary not only for prescribing glasses and contact lenses but also for determining whether you have an eye disease.

OVER

Self-Pay Patients

- Patients without health insurance are expected to pay a $100.00 deposit at the time of check-in, with any additional fees due upon completion of the visit.

Past Due Accounts

- Accounts with an outstanding balance of over 30 days will be deemed overdue. For balances which exceed $25.00, these accounts will be transferred to an outside collection agency. An administrative fee of $50.00 will be applied to the outstanding balances of Columbia Eye, and a $100.00 fee will be applied to the outstanding balances of Columbia Eye Surgery Center. Accounts with balances below $25.00 will be subject to internal collection processes.

- Accounts in bad debt must be paid in full before scheduling a future appointment.

Surgery Financial Policy

- We will obtain pre-certification and/or pre-authorization, if necessary, and verify your insurance benefits. We require all copayments, coinsurance, and deductibles to be paid prior to the date of the surgery.

- If prepayments are due to both Columbia Eye and Columbia Eye Surgery Center, they must be paid in two transactions. We cannot combine the two estimates into one transaction.

- Cancellations made less than 24 hours in advance may be subject to a $200.00 cancellation fee.

Optical

- Glasses, sunglasses, and contact lenses will be dispensed once full payment is received.

- Contact lenses must be paid in full before ordering.

- Half of the total cost of an eyeglass purchase must be deposited prior to ordering glasses. The remaining balance will be due at the time of pick up.

- If your account is in bad debt status, you will not be able to order glasses or contact lenses until the bad debt balance is paid in full.

I have read and understand Columbia Eye and Columbia Eye Surgery Center's Financial Policy and I agree to abide by its terms. I understand that I am financially responsible for all charges whether or not they are covered by insurance and agree that such terms may be amended from time-to-time by the practice.

_______________________________ _______________________________

Patient's Name (PRINTED) *Patient's Date of Birth*

_______________________________ _______________________________

Patient's Signature *Date*

____

Signature and Relationship if NOT Patient (ex: Parent, Child, Caregiver)