MICHIGAN Ophthalmology

FINANCIAL RESPONSIBILITY STATEMENT

Summary: It is your responsibility to:

- Provide photo ID and insurance cards at time of service, and promptly notify us of changes to your insurance plan or coverage.
- Know your insurance benefits and coverage, including whether PCP referral is required
- Provide payment for copay, coinsurance, or unmet deductible at the time of service
- Provide payment for any non-covered services at the time of service
- Pay any outstanding balances due to our office within 30 days of receipt

We reserve the right to refuse service to anyone who is not in compliance with this policy

Billing / Insurance Information:
You are encouraged to contact your plan via the Toll-free number listed on your card to confirm your benefits prior to your appointment. Additionally, we will verify the plan is active, and provide you with an *estimate* of your owed amounts for your visit (copay, co-insurance, unmet deductible).

Payment of your copay, co-insurance, unmet deductible, and any non-covered services including refraction fees* and contact lens fitting fees are due at the time of service.

> **** Refraction fee:***
> A refraction is the vision exam that determines your best possible vision ("which is better, one or two?"). We can provide this optional, non-medically-necessary service to you as part of your medical evaluation of your eyes, however, refractions are not typically covered by medical insurance. **If you request a copy of your prescription, a refraction fee of $50 is due at the time of service.** You may request that we bill your insurance, and if insurance does cover your refraction fee, we will reimburse the refraction fee immediately. All prescriptions expire after 12 months, and we do not provide copies of expired prescriptions.

Statement / Balance Payment
Following your visit, we will submit a claim for medically-necessary services to your insurance carrier. After we receive the explanation of benefits, any residual patient balances will be due and payable to our office within 30 days. Instances of overpayments will be refunded to you by our office per the terms of our Refund Policy (see below). Payments received greater than 30 days from invoice date may be subject to a 3% late payment fee. Failure to pay outstanding balances within 90 days of the statement date, may result in your account being submitted to collections agency, and subsequent appointments may not be made until balances are paid in full.

Elective Surgery and Premium Lens Fees:
Fees for services not covered by insurance, including LASIK or advanced technology intraocular lenses, must be paid in full no less than 7 days prior to services rendered. A written quote for premium lens fees, including deposit due will be provided to you upon request. Unpaid premium lens fees will result in postponement of your surgery.

Payment Method:

We accept the following payments: cash, check, money order, Visa, Mastercard, American Express, Discover, GreenSky and CareCredit. Credits cards may be kept securely on file for convenient balance payment and/or refunds.

Financing:
For premium surgical or laser services, we offer flexible 12 and 24 month 0% financing options via GreenSky Financial (www.greensky.com/provider/mieyedoc). Eligible services: laser cataract surgery, LASIK, advanced technology intraocular lens implants, Botox treatments, and IPL treatments for dry eye. Must apply and qualify.

Late Cancel / No-Show Policy
Once your appointment has been made, it will be reserved for you to ensure you get the quality care and attention you deserve. As such, please be courteous to your fellow patients by keeping your confirmed appointment. If you are unable to keep your confirmed scheduled appointment, please inform us as soon as possible, so that we may offer it to another patient. **24-hour notice of cancellation of your confirmed appointment is required, and late cancellation / no show fee of $50.00 may be charged to your account for no-showed appointments or those cancelled with less than 24 hour notice.**

Refund and Small Balance Policy
While we strive for accuracy in our patient financial responsibility estimates, small discrepancies between these estimates and actual insurance statements are common. In order to offer you the best possible service, following receipt of insurance payment and explanation of benefits, any residual balances or overpayments less than $5 will be applied to the balance due at your next visit. Refunds for amounts greater than $5 will be processed within 30 business days via the original payment method (ie. credit card refunds are applied to original card provided).

Acknowledgement
By signing below, each of the undersigned acknowledges that: (i) I have been provided a copy of the FINANCIAL RESPONSIBILITY STATEMENT; (ii) I have read, understand, and agree to their provisions and agree to the specified terms; (iii) I agree to pay all charges due (or to become due) for the below Patient's care and treatment, including copayments and deductibles, as required or provided pursuant to my insurance plan and/or the insurance plan of another, as applicable; (iv) benefits, if any, paid by a third-party will be credited on the Patient account.

ONCE I HAVE SIGNED THIS AGREEMENT, WHETHER BY ORIGINAL, FACSIMILE OR ELECTRONIC (".PDF") SIGNATURE, I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.

Signature: _____ Date: _____

Patient Name: _____

Responsible Party Name (if applicable): _____
Role (circle one): Patient/Responsibility Party/Guardian