MACADAM VISION CLINIC FINANCIAL POLICY

We want you to feel comfortable with our office regarding your financial and insurance matters and thereby prevent misunderstandings. We believe that you, our patients deserve the highest quality care we can provide at a reasonable cost. While we take advantage of every possible avenue to keep costs down, we are committed to not sacrificing quality for less expensive care. Please contact us if you have any questions regarding our services or our financial policies.

Often the assumption is made that if a person has insurance, then it is the insurance company who owes the doctor for his services. This assumption is incorrect. The insurance policy is between the patient and the insurance company alone. The patient is responsible for the bill regardless of insurance coverage determination. We will do our best as a courtesy to assist you in determining eligibility and benefits and billing your primary insurance company. We charge $25.00 to bill a secondary insurance. It is your responsibility to know the terms and any exclusions of your insurance coverage and to ensure your insurance carriers cooperation with us. Some insurance plans state that patients will be covered up to 50%, 80% or 100%. These are not percentages of what we charge but are percentages of the insurance company's "usual and customary" reimbursement. Another term similar to "usual and customary" is "maximum allowable." This term represents the maximum a patient's policy is allowed to pay toward a given service not the maximum we are allowed to charge.

Patients without insurance are required to pay in full at time of service. We offer a 30% time of service discount on professional services to our patients without insurance.

Patients with non-contract insurance are also offered a 30% time of service discount on professional services if they pay in full and bill their insurance themselves. We will provide the necessary paperwork to send to your insurance.

Patients with contract insurance are, at time of service, expected to pay their co-pay and what we estimate to be their portion not covered by their insurance. If we underestimate the portion not covered then the patient is responsible for the balance. If your personal payments plus the insurance payment exceed the total cost of service, the excess will be sent to you promptly after we receive insurance payment.

Vision-insurance and medical insurance serve two different functions. Vision insurance is in place to defray the cost of a vision examination for glasses or contacts and an eye health screening. Medical insurance defrays the cost of evaluation and management of disease or disease risk the vision exam may have revealed. You may be asked after your vision examination to return to our clinic for evaluation and management of eye disease or eye disease risk under your medical insurance. Medical insurance (not vision insurance) would also defray the cost of a visit for an eye disease or injury presentation. (E.g. pink eye, corneal abrasion or foreign body, glaucoma, cataract etc.) Medical presentation patients are expected at time of service to pay for a minimal Level 1 Evaluation/Management visit. We will bill medical insurance for the actual Evaluation/Management Level performed (1-5) and the patient is responsible for the balance or we will refund the overage after insurance payment is received.

- If there is no payment from your insurance company to our office within 45 days of service you are responsible for that balance at that time.
- Any balances unpaid after 30 days will be subject to a $5.00/month finance charge. Attorney or collection fees incurred while we attempt to collect balances will be your responsibility.
- We accept Visa, MasterCard and Discover credit cards. We do not accept post-dated checks.
- There will be a $50.00 charge for all returned checks.

Assignment and release: Your signature below hereby authorizes your insurance benefits to be paid directly to Greg W. Schober O.D. P.C. It also authorizes the doctor to release any information required for payment and processing of any and all insurance claims. Please sign below to acknowledge your understanding of the information on this sheet.

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Signature of Patient, Parent or Guardian Date