

VALLEY EYE ASSOCIATES FINANCIAL POLICY

Welcome to Valley Eye Associates. The following information outlines our financial policy. Your understanding of our Financial Policy is important. If you have any questions about this policy, please contact us at 920-730-4132, 800-344-4443, or e-mail us (preferred) at info@valleyeye.com.

INSURANCE BILLING

Please present your insurance card at each visit. It is your responsibility to inform Valley Eye of any insurance changes you may have. Valley Eye Associates is a participating provider in many insurance plans, including Medicare, Medicaid, United Healthcare, Network Health Plan, Humana, Blue Cross/Blue Shield, Vision Insurance Plan of America, Prevea, among others. If you are unsure if Valley Eye is a participating provider under your insurance plan, contact our Business Office at the number listed above. We will file a claim to your insurance company for services rendered by Valley Eye Associates, and we will work with you and your insurance company to resolve any insurance processing issues that may arise, however, you are ultimately responsible for payment of services provided by Valley Eye Associates. Should an overpayment be received from your insurance company, a refund will be made directly to your insurance company. Should an overpayment be received from you, a refund will be issued to you for amounts over ten dollars.

INFORMATION FOR MEDICARE PATIENTS

Please be aware that our office is a participating provider in the Medicare program and we accept assignment on all Medicare claims. It is important to know that Medicare does not cover all services. The refraction is a service that is not covered by Medicare, and is often times not covered by Medicare supplement plans either. Please be prepared to pay the refraction charge in full, if it is non-covered by your insurance carrier, at the time of service. Contact our Business Office at the number listed above if you have questions on the refraction charge.

CO-PAYMENTS

All co-payments are due at the time of service. Our office accepts cash, check or Master Card/Visa/Discover credit card payments.

(over)

AUTHORIZATIONS

It is your responsibility to obtain any necessary prior-authorizations for services as required by your insurance carrier. Should you arrive for your appointment without an authorization that is required by your insurance carrier, your appointment may be cancelled and/or rescheduled. If you are not sure if your insurance carrier requires prior-authorization for services, contact your insurance carrier directly.

I AGREE THAT I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OF VALLEY EYE ASSOCIATES, AND AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR SERVICES. I AUTHORIZE THE RELEASE OF ANY MEDICAL, OR OTHER INFORMATION NECESSARY TO PROCESS CLAIMS.

PATIENT

NAME: _____
Please print

PATIENT

SIGNATURE: _____
Sign Date

PARENT/GUARDIAN

NAME: _____
Please print

PARENT/GUARDIAN

SIGNATURE: _____
Sign Date