

Cape Fear Eye Associates, PA
Financial Agreement

Insurance Participation

We have contracts with and file claims for the following insurance companies: Aetna, Alliance PPO, BCBS, CIGNA, First Health, Health Care Savings, Humana Gold Choice, Med Cost, Medicaid, Medicare, PHCS, Southcare PPO, State Health Plan, Tricare, Wellpath, and United Healthcare

Third Party Payers

We do not file claims with third party payers for motor vehicle or other accidents. We will file your regular medical insurance if we participate and bill you according to insurance instructions if needed.

Eligibility Information

Our front desk staff will attempt to access eligibility, co-pay, co-insurance, and deductible information prior to your arrival. We will also ask to verify your insurance and scan your insurance card. If you do not have current insurance information, you will be required to pay for the services rendered and file your claim to receive reimbursement.

Claims Filing

We will file claims for those insurances with which we are contracted, as well as secondary insurance if we participate with your primary insurance. We accept the contractual write-off based on your primary insurance. Once we have received instruction from your insurance company, you will receive a bill for any outstanding balance. You will then be responsible for that balance.

Keep us informed

Most often errors in billing and claims payment are related to incorrect information. Please update us with name, address, phone number and insurance information as it changes.

Payment

We accept Checks, Cash, Visa/MC and Debit cards. All payments for service are due on the day the service is provided. We also offer Care Credit for those who are qualified.

Co-Pays

Many plans require that a patient pay a co-pay at each visit. We are bound by our contracts with insurance companies to collect that co-pay at the time we render our services. In keeping with our contracts, we will collect your co-pay when you check in. If co-pay is not paid by check-out on the day your services are rendered, a fee of \$10.00 will be added to your account. Patients with a history of not paying co-pays may be discharged from our practice, and we will notify the insurance carrier.

Co-Insurance and Deductibles

To avoid collection issues and increased billing costs, we will collect any percentage co-insurance or deductibles not met at the time of service. These amounts are calculated based on our negotiated fee schedule with the insurance company.

No-Shows

The following fees apply to no-show visits. \$25 fee for regular appointment, \$50 for procedures. Please try to give our office 24 hours advance notice of cancellation so that we may offer that appointment to another patient.

Patient Refunds

Refunds for overpaid services are issued by the 30th of each month.

Small Balances

You will not receive bills for balances less than \$5. However, we will notify you on your next visit of the balance.

Returned Checks

We charge a \$25 fee for returned checks. Patients who have written more than one returned check will be required to pay by cash. Multiple returned checks may result in discharge from the practice.

Delinquent Accounts

We will make attempts to contact you by phone and by mail regarding delinquent accounts. Failure to pay will result in accounts being turned over to collection agency. If your account is turned over, we will no longer offer medical care to the guarantor of the account or any family members for whom that guarantor is responsible.

Bankruptcy

Accounts written off due to bankruptcy will also result in termination from our practice. However, you may work with your Bankruptcy attorney to draft a letter expressing your intent to pay our bill and continue as a patient.

Charge for Medical Records

Medical records requested will be copied for the following fee: .75 per page 1-25, .50 per page 26-100, .25 all others, with a minimum fee of \$10. Postage is also charged.

Forms

Forms that require significant time to complete or must be completed repeatedly will be done for a charge of \$25. The Physician will make the determination of charging.

By signing below I agree that I have read the above financial agreement. I understand and agree to adhere to the policies included within the agreement.

Patient/Guarantor Name: _____

Pt. /Guarantor Signature: _____

Date: _____ Chart # _____