

# KEVIN B. WYNNE O.D. PLLC

## Office and Financial Policies

### **PAYMENT IS EXPECTED AT THE TIME OF SERVICE**

We accept cash, checks, credit cards and Health Savings Account Credit Cards in this office. There will be a \$25 fee in addition to the insufficient funds bank charges for all checks returned by the bank.

COPAYMENT and DEDUCTIBLE PLANS- Payment is expected at the time of visit for those who have a copayment or deductible insurance plan. This is a requirement set by your insurance company. There will be an additional \$15 charge for co-payments and deductible not received at the time of service.

SELF PAY OR PATIENTS WITH PRIVATE INSURANCE are expected to pay for services IN FULL at the time of service. Our office will provide you with an itemized bill so that you may submit the charges to your insurance company for reimbursement.

GLASSES and CONTACT LENS ORDERS- A minimum deposit of 50% of the total charge must be paid at the time that the materials are ordered. The balance is due when the finished glasses or ordered contact lenses are delivered to the patient.

### **INSURANCE/INSURANCE CLAIMS**

Please inform our front desk of any insurance that will cover your visit either prior to your visit or at the front desk upon your arrival in our office. It is your responsibility to make sure that you have provided this office with your current insurance information and for knowing if this provider is within your network. Due to the insurance company filing limits and specific handling of insurance claims, this information cannot be accepted after the time of your visit. If the insurance provided by you is not correct, you will be responsible for all balances on your account.

Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. **All charges not covered by your insurance company are your responsibility and must be paid in full within 30 days.**

### **APPOINTMENTS**

If you are late to your appointment (more than 15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.

We strive to minimize any wait time however emergencies do occur and will take priority over a scheduled appointment. We appreciate your understanding.

You may receive text messages sent to your cell phone containing appointment reminders or visit review requests. If you do not wish to receive appointment reminder texts, please check the box and initial:

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### **CANCELLED APPOINTMENTS**

If you are unable to keep your scheduled appointment, please call our office at least 24 hours before your appointment to reschedule. This will allow time to provide that time slot to another patient. As a courtesy to you, this office does not engage in the common practice of double or triple booking.

Therefore, your appointment slot is reserved for you alone. We reserve the right to charge \$50 for appointments that are not cancelled at least 24 hours in advance. Multiple missed appointments will result in dismissal from the practice.

### REFERRALS

It is your responsibility to understand your insurance benefit plan. You must know if a written referral or authorization is required to see the doctor in this office and what services are covered by your plan.

### STATEMENTS/DMV FORMS/Rx REQUESTS/PHARMACY REQUESTS

You will be given a copy of your statement at check out. This form will detail all services, materials purchased and all payments made by you. Please keep this form for tax purposes if needed. Please allow up to 72 hours from the time of request for this receipt to be regenerated for you. Please allow up to 72 hours for Rx refill requests, pharmacy Rx requests or for the completion of DMV forms.

### OVERDUE BALANCES

Patient balances more than 30 days old will incur a monthly billing fee of \$15 per month until the balance is paid in full. Any balances left unpaid after 90 days will be turned over to the collections company who will report the overdue balance to the 3 major credit bureaus and will institute collection proceedings. In the event that an account is turned over to collections, the person financially responsible for the account will be responsible for all collection fees including attorney fees and court costs. Failure to pay balances due may result in dismissal from the practice.

### CREDITS ON ACCOUNT

Credit amounts of \$10 or less will be retained on account and credited toward future balances for you or for family members at your request. Amounts in excess of \$10 will be refunded to you at your request or can be held on account for a future visit.

### MEDICAL RECORD COPIES

Any patients requesting copies of their medical records will be charged .75 per page plus postage.

### MINORS

The parent (s) or guardian (s) is responsible for full payment and will receive all invoices and billing statements.

**I have read and understand this office financial policy and agree to comply with all of the provisions contained within it. I have been given an opportunity to speak with someone in the office if I needed any clarification.**

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<b>Patient Name (printed)</b>	<b>Signature</b>	<b>Date</b>
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<b>Responsible Party Printed Name</b>	<b>Signature</b>	<b>Date</b>
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**Relationship to Patient**