NOLA OPHTHALMOLOGY

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An Nguyen, MD

FINANCIAL AGREEMENT

We are committed to providing you with the highest level of service and quality care. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, however, any and all financial liability rests with the patient.

INSURANCE

Our office participates with many major insurance plans. We provide **MEDICAL and SURGICAL** ophthalmologic care to our patients, as opposed to **routine vision exams**. We do not participate with **ANY** vision plans (VSP/Davis Vision, etc.). **If you have a managed care plan (ie HMO POS) that requires a referral to see a specialist, you must obtain a referral in order for your visit in our office to be covered under your medical insurance.** If you do not have the valid referral and still wish to be seen, you will be asked to pay for the visit prior to your examination.

PATIENT RESPONSIBILITY

It is the patient's/parent's/guardian's responsibility to:

1. Be familiar with the benefits of your plan, including co-pays, co-insurance and deductibles.
2. Bring all of your current insurance cards to all visits.
3. Provide our office with current information including address, phone numbers and employer.

REFRACTION

A refractive examination is not a covered service by most insurance companies, including Medicare. If you receive a prescription for glasses, you will be charged **$35** which is payable at the time of the visit. Should your plan pay us for the refraction, we will reimburse you accordingly.

FORMS

There is a charge for completing various forms, including your DMV form. Pre-payment is required for completing forms, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication.

MINOR/DEPENDENT PATIENTS

For all services rendered to minor/dependent patients, we will look to the adult accompanying the patient and/or the parent or guardian with whom the child resides for payment. In cases of separation or divorce, when presenting insurance cards for a dependent enrolled under a

subscriber other than you, please be prepared to supply their name, address, phone number, date of birth and social security number. We request that you inform the subscriber that their insurance has been used.

MISSED APPOINTMENTS

There will be a $**25.00** charge if you fail to show for any scheduled appointments or cancel the same day as your appointment. Any patient who cancels a scheduled, elective surgery without giving more than two (2) business days notice prior to surgery, or does not show up for surgery, will be charged a cancellation fee of **$100.00**. Legitimate emergencies will be taken into consideration.

PAYMENT

In accordance with your insurance contract, you must be prepared to pay all applicable payments, co-pay, and/or deductibles at each visit. We accept cash, checks, and all major credit cards for services.

Any check payments that do not clear the bank will be subject to a **$30.00** returned check fee.

We appreciate prompt payment in full for any outstanding balance. Your account may be turned over to a **collection agency** if you have a balance that is **90 days past due**. This may affect your **credit score**. If your account is turned over to our collection agency, you agree to pay any fees imposed by the collection agency in order to collect the overdue amount.

I hereby acknowledge and agree:

- that payment is due at the time of treatment, unless other arrangements are made.
- that parents/guardians are responsible for all fees and services rendered for treatment of a minor child.
- to accept full financial responsibility for all charges not covered by insurance.
- that I have received a copy of this agreement for my records.

I have read, understand, and agree to the above financial policy.

____ __________________
Signature of patient/guardian/parent Date

____ __________________
Printed name of patient Date