PATIENT FINANCIAL POLICY

As a patient at Ophthalmology Limited, you have the right to, upon request:

- *Receive, prior to treatment, a reasonable estimate of charges for medical care.*
- *Receive a copy of an itemized bill and to have the charges explained.*
- *Full information and necessary counseling on the availability of known financial resources for your care.*

PAYMENTS

We accept cash, checks, all major credit cards, and Care Credit Financing. Co-payments are due at the time of service unless you have established a payment plan with the Revenue Cycle Department. You will also be billed for any coinsurance and deductible amounts as well as noncovered services.

If you are being seen for a related service during a postoperative period, we will not collect a co-payment for the related postoperative visit. However, tests and medical supplies provided within a global period or an unrelated visit/service are separately billable and any balance after the insurance processes your claim will be your responsibility.

INSURANCE

We are a participating provider with most major insurance carriers. We will file a claim to your insurance company for services rendered by Ophthalmology Limited. You are expected to present insurance card(s) at each visit. Failure to provide valid and complete insurance information at the time of service may result in you being responsible for payment for services usually covered by an insurance plan. If you provide health insurance information after the insurance company's time guidelines for filing a claim, you will be responsible for payment of services denied for timely filing by your insurance company. Additionally, it is your responsibility to communicate any changes to your insurance or demographic information to Ophthalmology Limited in a timely manner.

If your insurance plan requires a referral for specialist services, it is your responsibility to contact your Primary Care Physician (PCP) to obtain a referral. You may be financially responsible for any visits denied due to no referral.

NON-PARTICIPATING INSURANCE PLANS

If you choose to use your out of network insurance, you will be responsible for the full payment. Some insurance companies have out of network benefits but the deductibles and co-insurance may be higher. We are not bound by the fees of companies who reimburse based on an arbitrary "schedule of fees".

Ophthalmology Limited does not participate with any vision plans and they will not be billed. Any balances are the responsibility of the patient. A detailed receipt of payment can be obtained from the Revenue Cycle Department for you to submit to these plans for possible reimbursement.

NON-COVERED SERVICES

This office offers some services and procedures that are deemed "not covered" by insurance companies. You will be given advanced notice of non-coverage before the services are provided. You will be responsible for payment in full prior to services being rendered. Non-covered services may include but are not limited to specialty lenses, refractive procedures, oculoplastic and dry eye treatments.

A refraction is a diagnostic test to determine your best corrected vision. The refraction also determines if there are any eye diseases causing vision loss. Refractions are not covered by most medical insurance plans or Medicare. This diagnostic test must be paid at the time of service.

DEPENDENT

If you are a dependent who consents to health care services on your own behalf, but utilize your parent's or guardian's insurance policy to pay for your services, please know that your parent or guardian will receive an Explanation of Benefits describing the nature of the services provided and, as a result, these services will no longer be confidential. Please speak with our staff if you wish to pay for your services in another manner.

MINOR CHILDREN/CHILD CUSTODY CASES

Services for minor children will be billed to the insurance company on file. The adult who signs the consent forms accepts full responsibility for payment for services rendered. We will not split bill between parents at any time. Statements for outstanding balances will be sent to the adult who signed the consent for treatment.

SELF-PAY ACCOUNTS

If you have no medical insurance coverage, full payment is expected at the time of service. Uninsured patients will receive a 20% discount off our standard fees if paid in full at the time of service. A Patient Accounts Specialist will contact you to discuss a payment plan if you are unable to pay your balance in full.

PAYMENT PLAN

If you are unable to pay the amount due by the due date, please contact our Revenue Cycle Department at (605) 271-6438 to set up an acceptable payment plan.

PATIENT COLLECTIONS POLICY

Your outstanding balance will be considered past due 30 days from the first statement. If you are unable to pay the balance in full within the 30 days, please call the Revenue Cycle Department at (605) 271-6438 to establish a payment plan. Any past due outstanding balance may be sent to a third-party collection agency and may also impact access to further appointments. Ophthalmology Limited reserves the right to discharge a patient from the practice for non-compliance if a balance is sent to Ophthalmology Limited's collection agency.

FINANCIAL HARDSHIP ASSISTANCE

If you do not have insurance and need assistance paying for services, you may apply for Financial Hardship Assistance. Financial Hardship Assistance paperwork must be completed and submitted within 14 days of the initial visit. Once the information is received by Ophthalmology Limited, it will be reviewed, and a determination will be made on eligibility.

PATIENT FINANCIAL POLICY ACKNOWLEDGMENT

I hereby acknowledge that I have read the Patient Financial Policy form, understand its content, and have been given the opportunity to have my questions addressed.

______________________________ Patient Name (Printed)

_____/_____/_____ Date of Birth

______________________________ Patient Signature

_____/_____/_____ Date

I hereby sign on behalf of the patient listed above. I acknowledge that I have read the Patient Financial Policy Form, understand its content, and have been given the opportunity to have my questions addressed.

______________________________ Authorized Representative Name (Printed)

______________________________ Authority (POA, Guardian, etc.)

______________________________ Authorized Representative Signature

_____/_____/_____ Date