Financial Policy, please read carefully!

Thank you for choosing us as your Ophthalmology provider. We are privileged to serve you and are committed to providing the best care possible.

Health Insurance: We participate in numerous health insurance plans. **Please note: we do not accept vision coverage plans**. For most insurers, we accept assignment of benefits but in all cases we require that the guarantor, the person who is financially responsible, to be personally liable for the balance not covered by insurance. **Please be aware that some, and perhaps all, of the services provided may not be completely covered by your insurance company.**

Please Initial the one option you prefer for charges not covered by your insurance:

☐ **I will pay in full. I have provided accurate and current insurance, addresses and phone numbers to the front desk.**

☐ **I would like to sign-up for a payment plan.**

We do not guarantee that your insurance company will pay for services rendered. **We recommend that you contact your health insurance provider to verify your coverage**. **It is your responsibility to know your benefit plan.** It is your responsibility to know if/when you need a referral from your primary care doctor and to know the extent of your coverage. Failure to provide complete insurance information may result in patient responsibility for the entire bill. 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.

Please note: If our physicians do not participate in your insurance plan or if you do not have health insurance, payment in full is expected from you **at the time of your office visit**. For scheduled appointments, prior balances **must** be paid prior to the visit.

Past Due Accounts: It is our office policy that all past due accounts be sent two statements. If payment is not made on this account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and you will be discharged from the practice. $12 plus postage fee that we pay to secure past due balances will be added to your account. If your account is submitted to an outside collection agency, you give your permission to release the necessary information, personal or otherwise, to the outside agency and you acknowledge that you are aware that this information may become a matter of public record.

Returned Checks: A $40.00 fee plus any bank fees will be charged for each check returned to us unpaid by your bank.

Cancellation/No-Show Policy: In order to schedule patients for the care that they need, and for the consideration of other patients, we require a 24 hour cancellation notice. **If a patient fails to show up for an appointment or to cancel 24 hours in advance, a $75.00 fee is charged to the patient for each missed appointment.**

Deductibles, Co-Pays and Coinsurance: All co-pays are due in full at the time of service as required by your health insurance company. In addition, you are responsible for any and all deductibles and coinsurances. We accept credit card, check, and cash. Absolutely no postdated checks will be accepted.

Please Note: We are considered a specialist and this co-pay amount may be more than your regular co-pay.

Release of Information: By signing this form you agree to allow Northern Illinois Eye Clinic/Dr. Emily Velotta to release pertinent medical records to government agencies, insurance carriers, and others who are financially responsible for such professional and medical care, all information needed to substantiate claim and payment.

Billing Information: It is essential that you provide us with complete and accurate information to submit billing to your insurance company (i.e. home address, phone numbers). We will make every effort to submit claims to your insurance company and promptly provide you our statements. However, if for any reason the statement is returned to our office because of a problem with an address you provided, you may be dismissed and referred to a collection agency. To avoid this, please keep your information up-to-date.

Workers' Compensation and Automobile Accidents: In the case of a workers' compensation injury or automobile accident, you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier **prior to your visit.** If this information is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service.

Other: Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

Non-covered charges and balances are due at time of visit. Unfortunately, we have had a large increase in patients not paying their bill for services provided. We therefore are requiring all patients to provide a credit card or $300 cash at time of service. I have read this Financial Policy and I agree to terms and conditions outlined within this Policy. I hereby consent to medical care and treatment deemed necessary and proper by my Ophthalmologist. I agree to assign all health insurance benefits directly to the above-named provider and understand that I am responsible for any costs not covered by my health insurance. Furthermore, I hereby authorize Northern Illinois Eye Clinic, LLC, at their sole discretion without any further notice to me to charge on my behalf on the below-specified credit card for any or all of the then-current balance due and owing on my account ninety (90) days after the date of the service provided to me.

Name on credit card (exactly as it appears):

____

Credit card number:

____

Verification code: _________ Expiration date: ____

Type of card (check): Visa Mastercard Discover

______________________________ __________

Signature of patient, POA or legal guardian **Date**

Revised 01/31/2023