GFEA Financial Policy, Permission to Treat, and Assignment & Release

OUR FINANCIAL POLICY

Thank you for choosing Glens Falls Eye Associates as your healthcare provider. We are committed to providing the best medical care possible.

Please understand that payment of your bill is essential for us to continue our services. Accordingly, we ask all of our patients to pay for their care at the time they receive their services. The following statement explains our Financial Policy which we ask you to read and sign prior to your treatment. A copy will be provided to you upon request.

All patients should provide accurate and complete personal and insurance information prior to being seen by the doctor. All applicable co-pays, personal balances, both current and prior, are due at time of service. We accept cash, check, Visa, Master Card & Discover.

Regarding Insurance

We participate in most insurance plans, including Medicare. For some insurance companies, we accept assignment of benefits, but in ALL cases we require that the guarantor (the person who is financially responsible) be personally liable for all balances not covered by insurance.

If you are NOT insured by a plan we do business with, OR if you are insured by a plan we do business with, but do not have an up-to-date driver's license and current valid insurance card to provide proof of insurance, payment in full is expected at each visit.

Please be aware that some, and perhaps all, of the services provided may be non-covered services or may NOT be considered medically necessary under the Medicare Program or by other insurance companies. You must pay for these services in full at the time of visit.

REFRACTION: This is part of the exam performed by the physician or technician to determine the need for a new eyeglass prescription. Medicare DOES NOT pay for refractions and neither do most insurance plans. The fee for this is $35.00 and is payable at the time of service.

Claims Submission

We will submit our claims and assist you in any way we reasonably can to help you get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Your insurance benefit is a contract between you and your insurance company; we are not party to that aspect of the contract. If your insurance company does not pay our claim the balance will automatically be billed to you.

Coverage changes

If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim, the balance will automatically be billed to you.

Referral Responsibility

If the appropriate referral(s) are no longer effective or have not been obtained properly from the primary care physician, the patient or guardian is financially responsible for all charges.

Missed Appointments/No Show Policy

We do our best to notify our patients one to two business days prior to their appointment in order to confirm. However, it is ultimately the patient's responsibility to keep track of scheduled appointments. Out-dated contact information is the most likely reason we are unable to confirm a patient's appointment. Therefore, keeping your information up-to-date will help us to contact you not only for reminders, but also for unpredicted schedule changes.

A missed appointment is a lost opportunity for someone else to receive care. Please help us to serve you better by keeping scheduled appointments. **Unless cancelled at least 24 hours in advance, our policy is to charge $50.00 for a missed appointment. If special testing is also scheduled and missed, there will be a total charge of up to $75.00 for multiple missed appointments in one day.** This fee is not covered by insurance so it will be the responsibility of the patient or guardian. Exceptions are few and are limited to true emergencies.

Past Due Accounts

Accounts are considered past due after 90 days. **Patients who are sent additional statements after 90 days will**

have a statement handling fee of $10.00 charged to each statement. This fee is not covered by insurance so it will be the responsibility of the patient or guardian. Overdue accounts will be referred to a collection agency if past due and arrangements have not been made. Fees that we pay to secure past due balances may be added to your account. Once an account has been referred to collections, Glens Falls Eye Associates reserves the right to terminate the patient-doctor relationship and only continue services for thirty (30) days for emergencies as per New York State law, and only on a cash basis.

Co-Payments and Deductibles

All co-pays must be paid at time of service, and deductibles must be collected when the amount has been determined by your insurance company. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payments at each visit. We do our best to calculate your co-pay accurately. If we overestimate your charges, the excess will be credited to your account or a refund check will be issued. If we underestimate your charges, the remaining balance will be billed to you.

If co-pay balances are not paid on date of service, a $25.00 fee may be charged to your account if not paid within 30 days. This fee is not covered by insurance so it will be the responsibility of the patient or guardian.

Form Fees and Copies of Medical Records

Completing insurance forms, DMV forms, disability paperwork, etc. requires time away from patient care. There is a $10.00 administrative fee for filling out such forms. In addition there may be a per page charge for copies of medical records in accordance with new York State law. The practice requires 2 business days to prepare medical records and up to 5 business days for other forms that must be filled out.

Returned Checks

Checks returned for any reason will be assessed a $50.00 fee in addition to the fees charged by the bank. These fees are not covered by insurance. The amount of the check will be expected to be paid immediately with a credit card, cash or cashier's check.

Consent for Medical Treatment

I am the patient or the patient's duly authorized representative, and do hereby voluntarily consent to and authorize care encompassing all diagnostic and therapeutic treatment regimens necessary in the judgment of my provider, for myself, my minor child, or other. I am aware that the practice of medicine is not an exact science. I acknowledge that no guarantees have been made to me as a result of treatments or performed examinations.

I do hereby authorize the release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me and to Glens Falls Eye Associates.

I also authorize the following individuals to have access to my account and/or medical records:

I have read this form completely, have had the opportunity to ask questions, and have been fully informed as to the contents of this agreement.

Signature:

Parent/Guardian Signature:

Date: