OUR FINANCIAL POLICY

Thank you for choosing Briggs Ophthalmology & Associates, SC as your healthcare provider. Our practice is committed to providing the best treatment and care possible for our patients. If you have 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, any and all financial liability rests with the patient.

We provide MEDICAL and SURGICAL ophthalmologic care to our patients, as opposed to routine eye exams. We do not participate with ANY vision plans.

We require a copy of your current insurance card along with a picture ID at your first visit and we will ask for this information again throughout your years with us. Without a copy of your insurance card, your account will be considered a "self-pay" account. We require that you update your address, telephone and employer information with us whenever there is a change. We are not responsible for delinquent accounts due to lack of receipt of statements or other correspondence. Notices are assumed to be acceptable if they are returned to us as unclaimed, forwarding order expired, or otherwise undeliverable.

SELF PAY PATIENTS: Payment is due, in full at the time of service rendered.

We accept MASTERCARD, VISA, and DISCOVER credit cards, along with MONEY ORDERS and CASH. We do participate with CARE CREDIT.

Our office participates with most major insurance plans. It is the **patient's responsibility** to be sure our Doctor is in their insurance plan. Although we make every effort to obtain accurate information, a verification of benefits is not a guarantee that an insurance carrier will pay a medical claim. The insurance carrier makes the final determination based upon the specific plan negotiated by the insured or insured's employer. Consequently, the patient or guarantor remains ultimately responsible for the charges incurred during each visit.

HMO PLANS:

We do not participate with any HMO plans. You will be considered a self pay patient if you wish to be seen. We have limited participation with HMO/POS plans.

PPO PLANS:

We have agreed to accept the discounted rate from your plan; however, all co-pays must be paid at the time services are rendered.

- **NEW PATIENTS: IF YOUR DEDUCTIBLE HAS NOT BEEN MET a $100.00-$200.00 deposit will be required prior to being seen. Your appointment will be rescheduled until this requirement is met. Also, an additional deposit will be required prior to any eye procedure/surgery. The deposit(s) will be applied to your deductible and any overpayment will be reimbursed.**

MEDICARE:

As a participating provider, we will bill your Medicare carrier. You are responsible for your annual deductible and 20% co-insurance. We will be happy to bill your secondary payer as well. If a balance remains after we bill Medicare and your secondary insurance carrier we will bill you for the balance, which is payable by you upon receipt of our statement.

SECONDARY INSURERS:

We will bill your secondary carrier as a courtesy. Having more than one insurance DOES NOT guarantee that your services are covered 100%. Secondary insurers may pay a portion after your primary carrier pays. You are responsible for any balances after your insurance(s) has cleared.

VORKMAN'S COMPENSATION:
his office will file claims to your employer; you must provide us with the name of your human resources director nd/or benefits manager.

IINOR/DEPENDENT PATIENTS:
ny patients under the age of 18 must have a parent or legal guardian accompany them to every visit. The ccompanying adult is responsible for payment of the account. The responsibility for payment of the services ndered to minor children whose parents are divorced rests solely with the parent seeking treatment for the child. Regardless of judgments defined by your divorce decree)

ERVICES NOT COVERED BY YOUR INSURANCE:
ervices not covered by your insurance are payable in full prior to or at the time-of-service. We will try to provide rior notification if you are going to receive a service that we know is not or may not be covered by your insurance. ome of these services may include a $40.00 refraction fee, and serum drops.

OLLECTIONS:
Ve make every attempt to work with our patients before sending accounts to collections. Once an account has been nt to collections, the unpaid balance and a deposit must be paid before patient is seen.

ORMS:
Ve reserve the right to charge for forms to be completed. Fees vary depending upon the form.

ETURNED CHECK FEE:
here is a $20 banking fee for all returned checks. If your check is returned from the bank, we will not accept a heck as payment on your account. All future payments must be made with cash, money order or credit card.

ANCELLED APPOINTMENTS
is the responsibility of the patient to call and cancel scheduled appointments. If you are unable to make your ppointment, we ask that you give at least a 24-hour notice. If a 24-hour notice is not given, you will be subject to a ancellation fee of $50 to reschedule your appointment. This $50 fee will be applied at the time of your next visit. fter 3 cancelled appointments without providing at least 24-hour notice, we reserve the right to refuse to accept ture appointments from you.

ou will be assigned a patient account representative to answer all of your questions.
eel free at any time to contact our office. 219-322-2723