



SIEPSE LASER EYECARE FINANCIAL POLICY

Thank you for choosing Siepser Laser EyeCare. We are committed to providing you with excellent service in every area including billing and insurance claims filing. Please read and sign our Financial Policy.

Our practice participates in many Medical and Vision insurance plans. If your plan does not cover services provided by our physicians, payment in full is expected at the time of your visit. We accept cash, checks, VISA, MasterCard, Discover and American Express.

Please be sure to provide us with your most current insurance card(s) at each visit. We cannot properly file your insurance claim if we do not have accurate insurance information in your account. If you do not have your insurance card with you at the time of service we will be happy to see you but payment in full will be due at the time of service. You must bring your insurance card to us in order for the claim to be filed. Once payment has been received from your insurance company, we will gladly refund the patient payment less any applicable co-pays or deductible. We must emphasize that your insurance coverage is a contract between you and your insurance company. We are a specialty practice. We realize temporary financial difficulty may affect the timely payment of your account. It is your responsibility to contact us promptly for assistance in the management of your account. Remember we are here to help.

Currently all of the insurance plans we are contracted with require that we provide the patient's full name, date of birth, social security number and complete home address. If you feel uncomfortable providing us with that information, we will provide you with a bill so you can file your own claim with your insurance plan. If you choose to file the claim yourself, payment in full will be due at the time of service.

Office Visits: Eye Examinations have two portions, the eye exam and the refraction. The refraction is the measurement taken to determine if there is a need for glasses and if so, your glasses prescription. Refractions may be done for routine eye exams or medical exams. **Most insurance plans, including Medicare do not pay for refractions. You will be asked to pay for the refraction at the time of your visit. This \$47.00 fee is additional to any co-pay or deductible. If you currently wear, or wish to start wearing contacts, there is separate charge for the contact lens fitting which must be paid at the time of service.**

Many insurance plans require a referral/authorization for specialist office visits. You will need to obtain this referral/authorization from your primary care physician **prior** to being seen in our office.



Surgery: If you are having surgery we will assist in getting pre-certification or prior approval for your procedure. Please keep in mind that most insurance plans have deductibles, copayments, or both, associated with surgery, and you will be responsible for payment of these fees at the time of service. We suggest that you review your insurance plan prior to visiting our office, so you will be familiar with your insurance plan guidelines and requirements. Please be prepared to pay patient responsibility at the time of service.

Billing and Credit: Statements will be mailed monthly and are due for payment within 30 days. Monthly statements will follow until the account is paid in full. If you have any questions, please feel free to discuss them with our Insurance/Billing Department by call (610) 265-2020 ext 114 or (610) 265-2020 ext.121. If you have not paid your bill, or have not set up payment within 90 days, we will ask for assistance from our collection agency.

PROFESSIONAL COURTESY POLICY AND CODE CHANGE REQUESTS: We greatly value our privilege to provide medical care to all of our patients. In accord with state and federal regulations, it is potentially unlawful to accept “insurance only”, to waive copays, and/or to alter codes that accurately depict medical services rendered. For these reasons, the practice of making “professional courtesy” adjustments is strictly prohibited at all Siepser Laser EyeCare Practices, as is the practice to alter codes that accurately depict the services rendered.

CONSENT FOR TREATMENT

The undersigned Patient/Guardian has received a copy of our financial policy and hereby authorizes the physicians of Siepser Laser EyeCare, and the employees’, to perform any treatment or procedures they may deem necessary for the Patient’s treatment.

_____/_____
Signature of Patient/Guardian Date

I hereby authorize the staff of Siepser Laser EyeCare to release information to insurance carriers, appropriate physicians and/or Workers’ Compensation departments, as required, concerning my illness and treatments and authorize all payments made to Siepser Laser EyeCare. I understand that if I did not get prior authorization as required by my insurance, that I will assume all financial responsibility for such charges associated with my visit.

- I am aware of Siepser Laser Eye Care Office Financial Policy.
- I have been offered or have received a copy of Siepser Laser Eye Care’s “Notice of Privacy Practice.”

_____/_____
Signature of Patient and/or Guardian Date