Eye Consultants of Rhode Island, Ltd.

FINANCIAL POLICY

We are committed to providing you with the highest level of service and quality care. If you have medical 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, however, any and all financial liability rests with the patient.

Our office participates with most major medical insurance plans. **We do not contract with VISION PLANS.** Insurances vary in their coverage and it is the ***patient's responsibility*** to understand his/her medical benefits. Please bring your insurance card(s) to all visits.

REFERRALS: If you have a managed care plan, you must obtain a referral from your PCP prior to seeing our doctors. If your insurance company rejects our claim for services rendered due to lack of referral, you will be held financially responsible for all charges.

CO-PAYS, DEDUCTIBLES, AND CO-INSURANCE Patients are expected to pay AT TIME OF SERVICE all amounts known not to be covered by their insurance company. We accept cash, checks, and all major credit cards for services.

SELF-PAY: If you have no insurance or we do not participate with your insurance plan, payment is due at the time of your service. Under some circumstances, a payment plan may be made.

REFRACTIONS: A refractive examination is not considered a medical service and therefore it is not a covered service by most insurance companies, including Medicare. If you receive a prescription for glasses, you will be charged **$40.00** which is payable at the time of the visit.

MISSED APPOINTMENTS: In the event that you are unable to keep your appointment, please give us 24-hour/1 business day notice. There will be a $30.00 charge if you fail to show for any scheduled appointments or cancel the same day as your appointment. Any patient who cancels a scheduled, elective surgery without giving more than (1) week notice prior to surgery, or does not show up for surgery, will be charged a cancellation fee of **$200.00**. Legitimate emergencies will be taken into consideration.

OUTSTANDING BALANCES: We appreciate prompt payment in full for any outstanding balance. If your account is turned over to collection, you agree to pay any related fees. Any check payments that do not clear the bank will be subject to a **$25.00** returned check fee.

I have read and understand the above financial policy.

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Printed name of patient Date

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Signature of patient/guardian/parent