Mark A. Latina, MD, Vicki S. Kvedar, M.D., Karen Gladstone, O.D.
Financial Policy for Patient Care Services

To help our office provide the most efficient and reasonable health care services, it is necessary for us to have a Financial Policy stating our requirements for payment of services rendered to our patients. Patients are responsible for the payment of all services provided by our office. It is our policy to file for insurance payment as a courtesy to you if we have ***accurate*** and ***complete*** insurance information. The balance due is still your responsibility if we have not received payment from the insurance company within 30 days. If we receive duplicate payment from both the patient and the insurance company, we will then prepare a refund for any overpayment and send it to you.

If you have insurance and we file with your carrier, we ask that you pay any portion of the balance which is your responsibility according to your plan, i.e., any deductible, co-pay, co-insurance amounts, ***at time of service***. For Medicare patients, we will wait until we have received payment and have billed your secondary payer before billing patients for the balance.

Since we are not party to the agreement between you and your insurance company, we may ask that you assist us in contacting them in the event that services are not paid within 30 days. If you do not have insurance, and are not covered by either Medicare or Medicaid programs, you will be considered a **"SELF PAY"** patient, in which, ***Payment is due in full at time of service.***

Patient **"NO SHOWS"** and cancellations are a tremendous loss for a practice. Please have the courtesy to cancel within 24 hours if you cannot keep your appointment. This gives our practice the ability to fill your appointment with another patient. **Failure to give notice 24 hrs prior to your appointment will result in a $25.00 fee to be paid by the patient.**

- **Return Check fees for insufficient funds are $35.00 in addition to your bank charges**
- **If an account is forwarded to Collections, your fees may increase up to 200% in order to cover the collection costs.**

We ask that you read this policy and aid us in keeping our costs down by ensuring that we are able to be reimbursed for our services on a timely basis. We welcome the opportunity to answer any questions you may have in regards to this policy.

To help in this policy we ask that you assist us by:

1. Providing us with current and updated information on yourself and your insurance coverage

2. Make payment at the time of service for all co-pays, deductibles and co-insurances. If you are a self pay patient, please pay in full at time of service. If you need to make other arrangements, please contact our billing department.

3. Discuss your account balance only with the business staff or billing department for the physician. Please do not discuss the financial aspects of your care with the physician(s). It is important for them to be allowed to practice medicine and provide patient care.

NOTE: By signing this form you are acknowledging that you have read and agree to the terms of this policy.

PATIENT SIGNATURE DATE STAFF SIGNATURE

* Please note: Refractions (eyeglass Prescriptions) are not considered a medical necessity and therefore are not covered by most insurance plans, especially Medicare. A charge of $35.00 will be due at the time of the visit, if a refraction is performed.

Patients with insurances which require co-pays or deductibles will be required to have a credit card on file which would be used only in the event of an outstanding balance. This card can only be used for your co-pays, deductibles, co-insurances, or balances that are patient responsibility. When we apply your payment, a receipt will be mailed out to you for your records.

Patient Name: ______________________________ **Name on Credit/Debit Card:** _________________________

Address: ______________________________ **City & State:** ______________________________ **Zip Code:** __________

Type of Card: **Visa** **MasterCard** **Discover** **(Please Circle)**

Card Number: __________ __________ __________ __________

Exp Date: MM __________ **YR** __________ **Card Security Code:** __________ **(3 digits on back or 4 digits on front (AMEX).**

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PATIENT SIGNATURE DATE STAFF SIGNATURE