THE GULF COAST GLAUCOMA CLINIC

OUR PAYMENT POLICY

Please be aware that we expect your payment portion in full the day services are rendered. In order to facilitate this payment process, we suggest you call our office in advance of your visit to make any other arrangements, or to find out what your payment portion is.

Please select your "patient type" below to determine your payment portion.

MEDICARE PATIENTS

We participate with Medicare. You must pay your 20% co-payment at each visit unless your secondary insurance is part of the Medi-Gap/Crossover program with Medicare. If your deductible for the year has not been met, you must pay the remaining deductible.

MANAGED CARE PATIENTS

If you see us through Managed Care Company, please be sure that, if we need authorization from another doctor or the company that is obtained at the appropriate time (some appointments need to be approved in advance). We will want to be sure you are eligible at each visit. You will need to pay us for any co-payment or deductible as determined by your insurance contract. If you have any services that are performed that are not part of your managed care policy, then these additional items will be payable as per "self pay patients" below. If later, the insurance company denies payment to us because of a pre-existing illness, or cancellation of your master policy, you agree to be responsible for payment within 30 days of the denial.

PRIVATE COMMERCIAL INSURANCE OR SELF-PAY PATIENTS

You are responsible for the payment in full of all services rendered on your behalf at the time of the service. We will assist you by providing you with an insurance receipt that you can send directly to your insurance company. You, the patient, are expected to make payment in full and follow up with your insurance carrier to be sure you are properly reimbursed. Your insurance policy is a contract between you and your insurance carrier. We cannot guarantee payment of you claims by the insurance company. If the insurance company rejects your claim in full or in part, you still remain responsible for paying for services rendered. We know what your insurance company should be paying and will be glad to help you if we feel your insurance company is not reimbursing you properly.

SURGERY

We will file your insurance for you regardless of your insurance type, if you have surgery with us. This would include laser surgery in the office. We expect you to pay your payment portion as above the day services are rendered in the office, and on the first post-zoperative visit, if you have surgery as an out-patient at an ambulatory surgery center or hospital facility.

If you are having surgery, please inquiry, in advance, as to what your payment portion will be so that you will be prepared to make this payment as noted.

(OVER)

CREDIT

Established patients who have demonstrated good payment patterns may be extended credit at our discretion.

HARDSHIP CIRCUMSTANCES

Patients who are experiencing financial hardship, and have no income, and do not qualify for any insurance including Medicaid or disability may be treated for a reduced or no fee at our discretion. Contact us for more information.

We have established this policy so that no person will go untreated who has serious eye disease. This is part of our mission to end blindness from glaucoma.

COLLECTIONS

Occasionally, we find it necessary to place a delinquent account in the hands of a collection agency.

Should I default on my account, all costs of attorney's fees, interest, and cost of collections would be my responsibility.

PAYMENTS ACCEPTED

We accept cash, personal checks, American Express, Visa, Master Card, and Discover. If you are an out-of–state resident with an out-of-state checking account, we may ask you to use your American Express, Visa, Master Card or Discover in lieu of accepting your check. A returned check will incur a $35 service charge with us, and we will not accept personal checks from you in the future.

I have read the above payment policy of **THE GULF COAST GLAUCOMA CLINIC** and agree to comply with this policy.

Date: _______________ ____

Signature of Responsible Party

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Print Name & Address (if different from patient)

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(11/2014)