FINANCIAL POLICY AND BILLING PROCESSES

- **Payment Due:** I understand that payment is due when services are rendered. I understand there is a surcharge if I use my credit card. This surcharge is not greater than the total cost of accepting credit cards. I understand I can use a debit card, HSA card, check or cash with no additional fee.
- **Co-pay, Co-insurance and Deductibles:** It is my responsibility to know what my co-pay, co-insurance and deductibles are, and my obligation to pay this at the time of service. If I am not able to pay at the time of service and do not want to utilize the Credit Card on File option, my appointment may be rescheduled.
- **Insurance Coverage:** I acknowledge that the insurance cards I have presented are current and accurate.
- **Refractions:** Refraction is the process of determining if there is a need for corrective eyeglasses. It is an essential part of an eye examination and necessary in order to write a prescription for glasses. This is considered routine vision and this practice does not participate with any vision plans. Medicare and most medical insurance do not cover the fee for refractions. The office fee for a refraction is $60.00. I understand that I am responsible for this fee, and it is payable at the time of service, if not covered by my medical insurance.
- **Medical Plans that have Vision Benefits:** Some medical plans do have routine vision benefits; however, sometimes these vision benefits are with a different carrier than the medical plan. Kunesh Eye Center may be a participating provider with my medical plan but not my vision plan, as Kunesh does not participate with vision plans.
- **Participating Insurance Plans:** If the practice is not a participating provider in my insurance plan, I will be responsible for filing my own claims and I will be responsible for paying in full at the time of service.
- **Returned Checks:** Returned checks will be subject to a collection charge of $25.00.
- **Past Due Accounts:** An account is considered past due after 90 days. In the event the balance is not paid, the practice may place the account with a collection agency for the balance to be collected. The agency charges the practice a flat contingency rate of $30 for its collection services. This collection fee will be assessed to patient's outstanding balance at the time provider places the account with the agency for collection. I understand that I will be responsible for this and may not be able to be seen by my provider until the balance is paid in full. The practice does not accept post dated checks.
- **Medicaid:** The practice only accepts patients that have State of Ohio Medicaid. Kunesh Eye Center does not participate with most Managed Care Medicaid companies such as Buckeye, CareSource, or Molina. I understand that if I have Medicaid insurance, I will inform the office right away and may be responsible for payment.
- **Surgery Charges:** The practice will make every effort to determine my insurance benefits and to relay to me an estimated amount that I may owe for surgery charges. I understand that this is just an estimate and that I may incur additional charges after my claim is processed by my insurance company; including fees for the surgeon, facility, and/or anesthesia.
- **Authorizations:** Some insurance plans require a prior authorization for services by a specialist for medical services. I understand and agree to pay for services not covered as a result of my failure to obtain pre-authorization for treatment as required by my insurance policy.
- **Cancellations and No Shows:** I understand that if I cancel my appointment with less than 24 hours' notice or I do not show up for my appointment, it causes a hardship to the practice. The practice understands emergencies happen and will work with me, if possible. If a pattern of canceled/missed appointments is identified, I may be dismissed from the practice.
- **Self-Pay Patients:** I understand that payment is due in full at the time of my visit. When I check in, I will either agree to set up a credit card on file option or make a deposit of $200. At the end of my appointment, any amount due will be paid at that time or any amount overpaid will be credited to me immediately.

_____ _____
Signature of Patient Date

_____ _____
Printed Name of Patient Date of Birth

MRN: _____ 04/15/2024