Account #

# Financial Policy

Welcome to Fogg Remington EyeCare. We would like to take this time to acquaint you with the financial policies of our office. Our goal is to provide you with the highest quality care possible and have highly trained staff available to answer questions you may have regarding your treatment, insurance or billing issues. Staff members are available today or you may contact our Business Office by telephone at 559-226-3975.

Our office contracts with most insurance companies. If your health care expenses are covered by one of these plans, we require you pay all deductible, co-pay and co-insurance amounts at the time of service. We will bill your plan for the remaining balance. If we do not contract with your plan, we require payment in full at the time of service for office visits and minor procedures. Non-covered services and surgical procedures will require payment in advance which will be discussed with you at the time of scheduling. Services are rendered to each patient at their request; therefore, each patient is responsible to us for payment.

*A copy of your insurance card and a photo ID are required at each visit.* It is your responsibility to notify our office of any changes in coverage; this information will be kept in your medical file.

You will receive a monthly statement whenever a balance is due. Charges billed to your insurance plan will be noted on your statement until payment and/or an explanation of benefits (EOB) is received from your insurance company. We will bill your plan directly as a service to you; however, this is not a substitute of your responsibility for payment. Charges which have not been paid by the insurance company are your responsibility and patient balances are expected to be paid within 30 days of receipt of a statement once your insurance company has paid our office. Balances not paid within 45 days will be subject to a monthly finance charge of 1.5%. Returned checks will be subject to a $20 service charge.

Requests for alternative methods of payment or arrangements will be reviewed on an individual basis and our office will make every effort to work with our patients.

Patients who do not cancel an appointment within 24 hours will be responsible for a $25 cancellation fee.

One or more of our physicians have a financial interest in the following facilities:

Laser Eye Center
Fresno Surgical Hospital

*I have read the above policy and agree to comply with its provisions. I acknowledge that I am responsible to understand my insurance benefits and that I am responsible for payment of all medical services rendered. I understand that if I am covered by an insurance plan, Fogg Remington EyeCare may bill my insurance plan as a convenience to me, but that I am responsible for such charges until they are paid in full.*

*Assignment and Release: I hereby authorize my insurance benefits to be paid directly to Fogg Remington EyeCare and that I am financially responsible for services that my insurance company considers to be non-covered. I authorize Fogg Remington EyeCare to release any information required to process my claim.*

| Print Patient's Full Name | Responsible Party Signature |
|---|---|
| Print Responsible Party's Name & Relationship | Date |