CHARLOTTE OPHTHALMOLOGY
Center for Sight

PATIENT FINANCIAL POLICY

Thank you for choosing Charlotte Ophthalmology. We are committed to providing you with excellent service in every area including billing and insurance claims filing. Please read and sing our Financial Policy below:

Our practice participates in many Vision and Medical insurance plans. If your plan does not cover services provided by our physicians, payment in full is expected at the time of your visit. We accept cash, checks, VISA, Mastercard, American Express and Discover.

Please be sure to provide us with your most current insurance card(s) at each visit.

We cannot properly file your insurance claim if we do not have accurate insurance information in your account. If you do not have your insurance card with you, we will be happy to see you but payment in full will be due at the time of service. Your must bring your insurance card to us in order for the claim to be filed. Once payment has been received from the insurance company, we will gladly refund the patient payment less any applicable co-pays or deductibles.

Many insurance plans are no longer using the social security number as the patient ID, and have changed to using the Employer ID as the subscriber number. If you are not the primary card holder please make sure you give us the correct subscriber (employee) ID number at the time of your visit.

Currently all the insurance plans we are contracted with require that we provide the patient's full name, date of birth, social security number, and complete home address. If you are uncomfortable providing us with this information, we will provide you with a bill so you can file your own claim with your insurance plan. If you choose to file the claim yourself, payment in full will be due at the time of service.

Copayments are required at the time services are rendered.

Eye examinations have two portions, the eye exam and the refraction. The refraction is the measurement taken to determine if there is a need for glasses and if so, your glasses prescription. Refraction may be done for routine eye exams or medical exams. **Most insurance plans, including Medicare do not pay for refractions. You will be asked to pay for the refraction at the time of your visit. If you currently wear, or wish to start wearing contacts, there is a separate charge for the contact lens fitting which must be paid at the time of service.**

Many insurance plans require a referral/authorization for office visits. You will need to obtain this referral/authorization from your primary care physician **prior** to being seen in our office.

If you are having surgery, we will assist in getting pre-certification or prior approval for your procedure. Please keep in mind that most insurance plans have deductibles, copayments, or both, associated with surgery, and you will be responsible for payment of these fees at the time of service. We suggest that you **review your insurance plan** prior to visiting our office, so you will be familiar with your insurance plan guidelines and requirements. Please be prepared to pay patient responsibility at the time of service.

Thank you, and let us know if we can be of further assistance.

I CERTIFY that the information given to me in applying for payment under my insurance contract is correct. **I authorize any holder of my personal information, whether medical or otherwise, to release to any third-party payers (including Medicare, Medicaid, and other parties) information needed to process claims for health care benefits.** I request that payment of authorized health care benefits be paid and I assign the benefits payable for physician's services to the physician or organization furnishing the services. I authorize such physician or organization to submit a claim to my health insurance carrier or any other third-party payer including Medicare and Social Security Act, To **Charlotte Ophthalmology**. I understand that I am financially responsible for charges not covered by the insurance company, and I hereby guarantee timely payment in full of any such charges.

By signing Below, you are acknowledging that you have read and fully understand our Financial Policy.

Patient Signature (or Legal Guardian): _____ **Date:** _____