OCULOFACIAL PLASTIC SURGERY, PLLC
FINANCIAL POLICY

Thank you for choosing Oculofacial Plastic Surgery, PLLC for your medical care. We know you have many choices when it comes to your healthcare and we appreciate the opportunity to care for you.

Our Financial policy was created to clearly delineate the financial terms of our care. Please take some time to read this policy and contact our Billing Office at 936-560-5437 with any questions. It is necessary that you sign this document prior to our initiating care.

PAYMENT IS EXPECTED AT TIME OF SERVICE

Payment is required at the time of service unless other arrangements have been made in advance by you and/or your insurance carrier. This includes applicable and estimated deductibles, co-insurance and co-payments under your insurance policy. Oculofacial Plastic Surgery, PLLC accepts cash, personal checks (in-state only), money orders, VISA, Mastercard, Discover and American Express, Care Credit.

RETURNED CHECKS

Returned checks will be charged back to the patient's account with a service fee of **$35.00**. Such checks not redeemed in (20) working days may be assigned to the County Attorney. Resulting fees and collection costs are the responsibility of the patient and/or his or her financial representative.

COLLECTIONS

Patients with an outstanding balance more than sixty (60) days old must make arrangements for payment prior to scheduling future appointments. If payment arrangements are not made and the account is more than ninety (90) days delinquent, the account may be turned over to a collection agency. In the event your account is turned over to a collection agency, you will be responsible for the fee charged by the agency for collection.

You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

INSURANCE

As a courtesy to you, we will bill your insurance company. All deductibles, co-insurance and co-pays are expected at the time of service. We will also forward claims to all secondary insurances along with the appropriate Explanation of Benefits (EOB) from the primary carrier. Please make sure to inform the registration staff of any and all insurance policies as well as to provide them with all insurance cards. If you do not have your insurance card(s) with you, your account will be considered "Self-pay" until you provide us with your insurance cards.

DEFINITIONS

IN-NETWORK

We refer to "in network" as the insurance companies with whom we have a contractual agreement. If we are in network, we have agreed upon a pay scale with that insurance carrier.

OUT OF NETWORK/NON-PARTICIPATING INSURANCE

If we are not in network with your insurance carrier, we will bill your carrier as a courtesy. If payment is not received within sixty (60) days, the balance becomes your responsibility. You may contact your insurance company to determine why payment has not been made. Please be aware that you may incur more out of pocket expenses for seeing a doctor out of network. It is your responsibility to check with your insurance company for benefits prior to receiving services.

ACCEPT ASSIGNMENT

"Accept Assignment" means that we agree to accept payments from the insurance company for services rendered. Depending on your plan, you may be responsible for a portion of the contracted fees even if we are in network.

PRIMARY CARE PHYSICIAN REFERRALS

Some insurance plans require you to have a referral from your primary care physician in order to be seen in our office. You are responsible for securing these referrals from the office of your primary care physician prior to your appointment with us.

SELF PAY

If you do not have insurance coverage or the service being provided is not covered by your insurance, our Billing Department will ask for payment prior to surgery.

REFUNDS

If an overpayment is made on your account, by you, refunds will be processed within a reasonable timeframe. If your treatment is ongoing, we will apply the overpayment to any future balances, at your request. We will provide you with an authorization instructing us on the handling of your overpayment.

FMLA AND OTHER FORMS

There is a $20.00 fee for completion of paperwork requested by outside entities. Payment is expected at the time the paperwork is completed. Please allow seven (7) to ten (10) working days for completion

MISSED APPOINTMENTS/LATE CANCELLATIONS

Missing or arriving late for appointments without advance notice can cause delays for other patients. As a courtesy, we ask you to contact the practice 24 hours in advance if you will not be able to keep your scheduled appointment date and time. If you find that you must be late, please contact us as soon as possible so that we can determine if we need to reschedule your appointment. Excessive missed appointments may result in discharge from the practice.

I have read the Financial Policy and agree to the terms:

_____

Printed Name

_____ _____

Patient/Guarantor Signature Date