# Patient Financial Policy

Sun Eye Care, P.A.

**Thank you for choosing Sun Eye Care, PA.** We are committed to building a successful physician-patient relationship with you. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

**Co-pays**: You are expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted. Payment for the patient responsibility of charges is expected in full at the time of your visit. If you request to be mailed a bill, a $20 fee will be applied.

**Insurance Claims**: Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company, as a courtesy we will file your insurance claim on an unassigned basis, meaning that the insurance company will reimburse you directly and payment in full will be due at the time of your visit. If we are unable to file the claim on an unassigned basis, and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately. If your insurance claim is not paid by your insurance company in a timely basis (less than 60 days) you will be responsible for payment. If we later receive payment, we will refund the amount to you.

**Vision Plans:** With the exception of VSP, we do not participate in vision plans.

**Contact Lens Policy:** The fitting of contact lenses incurs a separate charge from your eye exam. The fee does not include the supply of contact lenses or where appropriate trial lenses. The fee charged for a contact lens fitting varies based on the complexity of the contact lenses being fitted and whether you have any eye diseases increasing the complexity of the fit (for example keratoconus). Please ask for an updated list of our current fees prior to scheduling your contact lens fitting. Also, be aware that some lenses require that you return for a follow up visit to determine that the fitting is correct. Our current fee schedule outlines how many of these return visits will be covered by your payment of the fitting fee. If you fail to return for your follow-up fit, your prescription may not be released to you. Payment for contacts is required at the time they are ordered. If you later choose not to receive them or do not return for follow up fitting as requested, your payment will be refunded provided that the vendor will accept the return. If they charge any re-stocking fees, those fees will be passed along to you.

**Non-Covered Services:** Not all insurance companies cover all services. In the event that your insurance company determines that a service to be “non-covered” for whatever reason, you will be responsible for the payment of those non-covered services.

**Referrals and Pre-authorizations**: Certain health insurances (HMO,POS, etc.) require that you obtain a referral or prior authorization from you Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain a properly dated referral and/or preauthorization for the correct provider may result in a lower or no payment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements such as changing the visit to self-pay or rescheduling of your appointment may be necessary if a referral is not obtained.

**Self-pay Accounts**: Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us or who present without an insurance card. Liability cases will also be considered self-pay accounts. We do not accept attorney letters or contingency payments. It is always the patient’s responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Patient examinations for emergency conditions or follow-up from Emergency Room visits

will be seen without regard to ability to pay at the time of the visit, however for patients unable to pay, payment arrangements will be made on a case by case basis. Extended payment arrangements are available if needed and we contract with CareCredit as an alternate form of payment. Please ask to speak with a billing coordinator to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

**Third Party Billing:** We do not do any third-party billing. Our relationship is with you and not with a third-party liability insurance (auto, homeowner, etc.). It is your responsibility to seek reimbursement for any such claims. However, at your request, we will submit a claim to your primary health insurance carrier. You may receive an accident questionnaire from them to be completed by you. If the questionnaire is not returned to your medical insurance company and/or we receive a denial on your claim, you will be responsible for payment in full.

**Workers' Compensation:** We do not contract with Texas Worker's Compensation, but on an emergency basis TWC may sometimes authorize payment for work related injuries.

**Non-Texas Residents: AGREEMENT AS TO GOVERNING LAW AND FORUM**

All patients not residing in Texas are hereby notified that (specifically New Mexico resident pursuant to New Mexico HB 270), as a condition of treatment you agree to be bound by Texas law. The patient, including patient's representative and heirs or beneficiaries, and the health care provider, including employees and agents of the health care provider, rendering or providing medical care, health care, or safety or professional or administrative services directly related to health care to patient agree:

1. That all health care rendered shall be governed exclusively and only by Texas law, and in no event shall the law of any other state apply to any health care rendered to patient; and
2. In the event of a dispute, any lawsuit, action, or cause of which in any way relates to health care provided to the patient shall be brought only in a Texas court in the county/district where all or substantially all of the health care was provided or rendered, and in no event will any lawsuit, action, or cause of action ever be brought in any other state. The choice of law and forum selection provisions of this paragraph are mandatory and are not permissive in the event that you should elect to file a tort

**Missed Appointments**

Sun Eye Care, PA requests a 24-hour notice of appointment cancellation. Missed appointments which are not previously cancelled may be charged a fee of $25.00 depending upon the circumstances for the cancellation. Patients who repeatedly cancel or no-show for appointments may be discharged from the practice.

**Returned Checks**: The charge for a returned check is $35 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

**Medical Record Copies**: Patients requesting copies of medical records may be charged depending upon the volume of the amount requested. Attorneys and Insurance companies will be charged a $15 fee, plus postage, plus: $.25 per page and $15 for an itemized bill.

**Minors**: The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

**Outstanding Balance Policy**: It is our office policy that all past due accounts be sent two statements. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account may be sent to the collection agency, or attorney, and possible discharge from the practice. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collection's costs including attorney fees and court costs.

I have read and understand the financial policy of this practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____ _____

Patient or Guardian Signature Date signed

# Waiver of Liability Notice of Noncoverage:

Private Insurance ONLY

Sun Eye Care, P.A.

The **Waiver of Liability Notice** is **used** to provide voluntary notification of financial liability for items or services that your private insurance may not cover for the services(s) listed below. Your private insurance does not pay for all your healthcare costs. Private insurance only pays for covered items and services based on your benefits and it is the responsibility of the insured to be aware of covered benefits. The fact that your insurance may not pay for a particular item or service does not mean that you should not receive it. However, you need to make a choice about receiving this/these health care item(s) or service(s).

***Private Insurance may not pay for the following item(s) or service(s).***

| | | | |
|---|---|---|---|
| Visual Field Test **$118-169** | (CPT Codes: 92081, 92082, 92083) | Corneal Topography **$115** | (CPT Code: 92025) |
| OCT **$118** | (CPT Codes: 92133, 92134) | Fundus Photos **$136** | (CPT Code: 92250) |
| Tear Lab **$53-106** | (CPT Code: 83861) | Pachemetry **$111** | (CPT Code: 76514 |
| B-Scan **$326** | (CPT Code: 76512) | Refraction Test **$42** | **OTHER:** |

***Reason for non-payment:*** Non-covered benefit service(s) and/or item(s)*:* _____

Please be advised that your insurance company will not decide whether to pay unless you receive the above item or services. If your insurance denies payment, you will be fully responsible for payment. That is, you must pay personally, either out of pocket or through any other insurance that you may have. You may appeal your insurance's decision.

Your private insurance allows that we may bill you for items or services and that you may have to pay the bill while your insurance makes its decision. If your insurance does pay, we will refund to you any payments made. The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain if you do not understand why your insurance may not pay.
- Ask us how much these items or services will cost you. (Estimated total cost: S_____)

PLEASE CHOOSE ONE OPTION

□ **YES**. _____ (Initial) I want to receive these items or services. Please submit my claim to my private insurance. I agree to accept financial responsibility in the event my insurance chooses not to pay.

□ **YES**. _____ (Initial) I want to receive these items or services, but do not bill my insurance. You will be asked to pay item(s) or service(s) at the time of service (***Discount Private Pay Rates Available***). I cannot appeal if insurance is not billed.

□ **NO**. _____ (Initial) I have decided not to receive these items or services. I understand that you will not be able to submit a claim to my insurance and that an appeal to my insurance will not be made.

_____ _____

(Patient Signature/Responsible Party) (Date)

_____ _____

(Witness) (Date)

Sun Eye Care, P.A.

# Advance Beneficiary Notice of Noncoverage (ABN-GA)

Medicare requires that you are given this form to alert you that Medicare may not pay for the services(s) listed below. Medicare does not pay for all your healthcare costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. However, you need to make a choice about receiving this/these health care item(s) or service(s).

***Medicare may not pay for the following item(s) or service(s).***

| | | | |
|---|---|---|---|
| Visual Field Test **$118-169** (CPT Codes: 92081, 92082, 92083) | | Corneal Topography **$115** (CPT Code: 92025) | |
| OCT **$118** | (CPT Codes: 92133, 92134) | Fundus Photos **$136** | (CPT Code: 92250) |
| Tear Lab **$53-106** | (CPT Code: 83861) | Pachemetry **$111** | (CPT Code: 76514 |
| B-Scan **$326** | (CPT Code: 76512) | Refraction Test **$42** | **OTHER:** |

***Reason for non-payment:*** Non-covered benefit service(s) and/or item(s)*:* _____

Please be advised that Medicare will not decide whether to pay unless you receive the above item or services. If Medicare denies payment, you will be fully responsible for payment. That is, you must pay personally, either out of pocket or through any other insurance that you may have. You may appeal Medicare's decision.

Medicare allows that we may bill you for items or services and that you may have to pay the bill while Medicare is making its decision. If Medicare does pay, we will refund to you any payments made.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain if you do not understand why Medicare may not pay.
- Ask us how much these items or services will cost you. (Estimated total cost: S_____)

PLEASE CHOOSE ONE OPTION

☐ **YES**. _____ (Initial) I want to receive these items or services. Please submit my claim to Medicare. I agree to accept financial responsibility in the event Medicare chooses not to pay.

☐ **YES**. _____ (Initial) I want to receive these items or services, but do not bill Medicare. You will be asked to pay item(s) or service(s) at the time of service. I cannot appeal if Medicare is not billed.

☐ **NO**. _____ (Initial) I have decided not to receive these items or services. I understand that you will not be able to submit a claim to Medicare and that an appeal to Medicare will not be made.

*This notice gives our opinion, not an official Medicare decision. If you have questions on this notice or Medicare billing, call 1-800-633-4227 / **TTY:** 1-800-486-2048. Signing below means that you have received and understand this notice. You also received a copy.*

_____ _____

(Patient Signature/Responsible Party) (Date)

_____ _____

(Witness) (Date)

# MEDICAL HISTORY UPDATE

Sun Eye Care, P.A.

Do you have a new primary care physician or change in power of attorney?

Name_____

Address_____

Pharmacy:_____

Address:_____ Phone #:_____

Since your last visit, have you been diagnosed with any new medical conditions such as diabetes, high blood pressure, heart disease or cancer? Please list them below along with treating physician.

| Medical Condition | Treating Physician |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Have you had any surgeries since your last visit? Please list them below with the name of the surgeon.

| Type of surgery | Surgeon | Year performed |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

List your current medications.

| | | |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Please list your drug allergies: _____

Has anyone in your family been diagnosed with any new diseases such as cancer, diabetes, glaucoma, or macular degeneration? Please list them below with the family member who was diagnosed.

| Name of Condition | Family Member |
|---|---|
| _____ | _____ |
| _____ | _____ |

How much alcohol or tobacco do you use? Alcohol: _____ Tobacco: _____

Do you use any street drugs: ◯ No ◯ Yes, Type: _____

REVIEW OF SYSTEMS: Please check any of the following that apply

**GENERAL SYMPTOMS**

- ❑ Good general healthy lately
- ❑ Recent unplanned weight change
- ❑ Decreased appetite
- ❑ Fever or night-sweats
- ❑ Fatigue, weakness or falling
- ❑ Obesity

**ALLERGIC/IMMUNOLOGIC** ☐ N/A

History of skin reaction or other adverse reaction to:

- ❑ Penicillin or other antibiotics
- ❑ Morphine, Demerol or other narcotics
- ❑ Novocaine or other anesthetics
- ❑ Aspirin or other pain remedies
- ❑ Tetanus antitoxin or other serums
- ❑ Iodine, merthiolate or other antiseptic
- ❑ Other drugs/medications:_____

Known food allergies: _____

Environmental allergies: _____

**CARDIOVASCULAR** ☐ N/A

- ❑ Heart problems or chest pain
- ❑ Palpitation or irregular heart beat
- ❑ Shortness of breath with walking
- ❑ Shortness of breath at rest or when lying flat
- ❑ Swelling in ankles, feet or hands

**EARS/NOSE/THROAT** ☐ N/A

- ❑ Hearing loss or ringing
- ❑ Earaches or drainage
- ❑ Chronic sinus problems
- ❑ Nose bleeds
- ❑ Mouth sores
- ❑ Sore throat or voice change

**ENDOCRINE** ☐ N/A

- ❑ Hormone or "gland" problem
- ❑ Thyroid disease
- ❑ Heat or cold intolerance
- ❑ High cholesterol
- ❑ Diabetes
- ❑ Excessive thirst or urination

**GASTROINTESTINAL** ☐ N/A

- ❑ Change in bowel movements
- ❑ Nausea or vomiting
- ❑ Frequent diarrhea
- ❑ Painful bowel movements or constipation
- ❑ Rectal bleeding or blood in stool
- ❑ Abdominal/belly pain
- ❑ Ulcers

**GENITOURINARY** ☐ N/A

- ❑ Frequent urination or awaken at night to urinate
- ❑ Burning or painful urination
- ❑ Blood in urine
- ❑ Incontinence or dribbling
- ❑ Sores or discharge
- ❑ Kidney stone
- ❑ Sexual difficulty
- ❑ Male – testicle pain/lumps
- ❑ Male – discharge from or sores on penis
- ❑ Female – painful or irregular periods
- ❑ Female – prior abnormal pap smear
- ❑ Female – vaginal discharge

Female – number of pregnancies_____

Female – number of miscarriages:_____

Female – date of last pap smear_____

**HEMATOLOGIC/LYMPHATIC** ☐ N/A

- ❑ Slow to heal after cuts
- ❑ Bleeding or bruising tendency
- ❑ Anemia
- ❑ Blood clots
- ❑ Blood transfusion
- ❑ Enlarged glands

**INTEGUMENTARY** ☐ N/A

- ❑ Rash or itching
- ❑ Change in skin color
- ❑ Change in hair or nails
- ❑ Varicose veins
- ❑ Breast lump or pain
- ❑ History of abnormal mammogram

**MUSCULOSKELETAL** ☐ N/A

- ❑ Joint pain
- ❑ Joint stiffness or swelling
- ❑ Weakness of muscles or joints
- ❑ Muscle pain or cramps
- ❑ Back pain
- ❑ Difficulty in walking
- ❑ History of bone fracture

**NEUROLOGIC** ☐ N/A

- ❑ Frequent or recurring headaches
- ❑ Light-headed or dizzy
- ❑ Convulsions or seizures
- ❑ Numbness or tingling sensation
- ❑ Shakes
- ❑ Paralysis
- ❑ Stroke
- ❑ Head injury

**OCULAR** ☐ N/A

- ❑ Eye disease or injury
- ❑ Wear glasses or contact lenses
- ❑ Blurred or double vision
- ❑ Glaucoma or cataracts

**PSYCHIATRIC** ☐ N/A

- ❑ Memory loss or confusion
- ❑ Nervous or anxious
- ❑ Worry about job, money, children or marriage
- ❑ Depression, frequent crying or easily upset
- ❑ Difficulty sleeping

**PULMONARY** ☐ N/A

- ❑ Chronic or frequent cough
- ❑ Exposure to tuberculosis or active tuberculosis
- ❑ Spitting up blood
- ❑ Shortness of breath
- ❑ Asthma or wheezing

**OTHER**

- ❑ _____

REVIEWED BY: _____ DATE: _____