## FINANCIAL POLICY AND AGREEEMENT

Rockville Eye Associates, P.C. strongly believes it is vital that our patients have a clear understanding of our financial policies. We invite you to discuss any questions or concerns you may have regarding our policies, services or fees with us at any time.

***IF YOU DO NOT HAVE INSURANCE***
Payment is expected at the time of service. If the service is extensive, we will be happy to discuss a financial payment arrangement for you.

***IF YOU HAVE INSURANCE***
Insurance is a contract between you and your insurance company. We will be happy to bill your insurance; however, it is your responsibility to provide us with current and correct information. Your insurance company makes the final determination of your eligibility for the services you receive. You are responsible for the portion of the charges which are not covered by your insurance.

***CO-PAYMENTS***
If we are contracted with your insurance carrier, we are required to collect copayments. Co-payments must be paid at the time of service. We cannot bill you for these fees. You may pay this fee with cash, check, or a credit card.

***REFERRALS***
If your insurance requires a referral from your Primary Care Physician, the referral must be presented before seeing the Physician. It is your responsibility to obtain the referral.

***MONTHLY STATEMENT***
If you have a balance remaining after your insurance pays their portion, we will send you a statement. Payment is expected within 15 days of receipt of the statement. If you cannot pay the full amount, please call our office immediately. We are always willing to discuss payment options and arrangements with you; however, if you simply ignore your responsibility to pay, we may be forced to take further collective action.

***DISPUTES***
You should notify us of any billing concerns or discrepancies. We will investigate your concerns and make every effort to resolve them as soon as practicable.

***RETURNED CHECKS***
You will be responsible for a $25.00 fee for any check returned by the bank.

*I have read and understand Rockville Eye Associates, P.C. 's Financial Policy. I acknowledge and agree that I am personally responsible and will pay for all charges, items, services and treatment provided to me, including any amount not paid by my insurance plan such as any non-covered services, deductibles and co-insurance payments established by my member benefit agreement/contract. It is my responsibility to comply with all requirements in a timely fashion and to supply all information and documents (such as insurance cards, referrals, etc.) necessary so that benefits may be reviewed, processed and assigned to Rockville Eye Associates, P.C.*

*I understand and agree that any balance remaining on my account after my insurance has paid its portion is my responsibility and will be due within fifteen (15) days of receipt of my statement unless other arrangements have been mutually agreed upon in advance.*

*If I do not have insurance, I understand and agree that I am responsible to pay my bill in full at the time of service unless a Financial Payment Agreement has been established in advance.*

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PATIENT/GUARANTOR ACCOUNT# DATE