LIFESTYLE EYE CENTER
Healthy You – Healthy Eyes

FINANCIAL POLICY

Lifestyle Eye Center is committed to providing you with the highest quality medical care. Because patients are ultimately responsible for the charges associated with their care, even when insurance is in place, you may find the following information to be helpful. If you have any questions or concerns about any of the information contained below, please discuss them with our staff. We appreciate your choosing Lifestyle Eye Center!

PATIENT RESPONSIBILITIES

You can help ensure an efficient experience by assisting with the following:

*Knowing your insurance benefits, limitations, and requirements
*Ensuring there is an authorization for our providers to treat you (if it is required by your insurance), including obtaining a referral
*Paying your portion of the charges at the time of service and additional amounts owed when due
*Providing us with 24+ hours advance notice should you need to cancel or reschedule an appointment

Please note that co-payments, co-insurance, and deductibles are a contractual agreement between you and your insurance carrier. We cannot change or negotiate these amounts.

MEDICAL INSURANCE

Our office participates with most medical insurance plans (though only part of the Washington Medicaid plans). We will submit a claim to your medical plan (we are unable to bill vision plans). For HMO's, PPOs, and EPO's valid authorization or referral at the time of service is required. If you choose to be seen without a referral or fail to inform us of any changes to your health insurance coverage, group, or ID number, you are responsible for charges due in full at time of service.

INSURED PATIENTS

Co-Pays/Deductibles/Co-Insurance – Be prepared to pay for your portion of the charges on the date of service.

Non-Participating Insurance – If we do not participate in the insurance you have, we will file a claim as a courtesy for most insurance companies. All unpaid claims will become your responsibility 45 days following filing and be immediately due and payable.

SELF-PAY / UNINSURED

Office Visits – A $350.00 deposit is required prior to your first appointment. This deposit will cover the initial visit and some or all diagnostic tests done that day. Additional testing above the deposit are to be paid before leaving. Any remaining funds will be applied towards your next visit. If you are not returning, we will send you a refund check for any overpayment. Each additional visit and testing is to be paid in full on the day of service.

Self-Pay Discount – If visits, services, and the physician portion of surgeries are paid in full before or at the time of service, we offer a 20% discount to patients with no outstanding balance (if outstanding balance is resolved at the time of service, then the discount would apply). The discounts do not apply in cases of motor vehicle accidents, third party insurance claims, or in other cases when the patient may be reimbursed in full.

Medicaid – Private pay patients who receive retroactive Medicaid coverage need to immediately notify our business office.

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DIAGNOSTIC TESTING

Additional tests may be done that are not included in your exam fee. Most will be covered by your insurance. Depending on your insurance plan, you may have a remaining balance to pay. You may ask questions and decline the tests before they are done if you do not wish to pay for them, though that may affect the outcome of your care, and in some cases our doctors may not be able to treat you without the needed tests.

WORKERS' COMPENSATION

If your visit is work-related, we will need the case number and carrier name prior to your visit in order to bill the workers' compensation insurance carrier. If your workers' compensation claim is not yet accepted and you have no other insurance, we require a $350.00 deposit which will be refunded after the claim has been opened.

SURGICAL FEES

When surgeries are performed in a hospital, our surgical fees are only for the surgeon's services. There will be separate charges from the hospital and anesthesiologist for their portion of the surgical costs.

Estimate Only Prior to your surgery, we will contact your insurance company to obtain eligibility and an estimate of your benefits for the surgeon's services. Remember that this is an estimate only, based on proposed services and information supplied by your insurance carrier.

Pre-payment For patients with insurance, you will need to pay half of your estimated co-insurance for the surgeon charges (this does not apply to Medicare patients or senior insurance plans). If you do not have insurance or if LEC is out of your network, you will need to pay the entire surgeon fees in advance. All pre-payments are due at least one week prior to services being rendered, or immediately if it is less than one week until the surgery date. Surgery slots are not reserved until payment is made. Please note: there are rare occasions when unforeseen circumstances require surgeries to be rescheduled even when fees have been pre-paid. Overpayments will be refunded.

DMV and OTHER FORMS

If you need any special forms completed in addition to the eye exam and testing (i.e. Motor Vehicle Vision, Military Vision, etc.) these services can be provided for a starting fee of $25, depending on the time involved.

NON-COVERED SERVICES

Some tests and procedures may not be covered by your insurance plan. If we anticipate this we will attempt to inform you beforehand. You will need to pay for any non-covered services.

NO SHOWS / CANCELLATIONS

Please provide us with at least 24 hours advance notice if you need to cancel or reschedule an appointment. Except for rare circumstances we will charge a $25 fee for missed appointments.

PAYMENT

Payment Options – We accept cash, checks, VISA, Mastercard, Discover, Care Credit (see below), and money orders for payment (no post-dated or third party checks). We charge a $40.00 NSF fee for any returned checks.

Care Credit - We accept Care Credit as a form of payment. It is a type of credit system that allows you to apply and, if accepted, it will pay for your services up front. You would then make payments to Care Credit until the services are paid for. They do charge interest. Let us know if you would like more information about Care Credit.

Delinquent Accounts – We charge 1% interest monthly on statement balances that are more than 30 days past due (once insurance has been resolved, or from the date of service for self-pay patients). We may assign an account to a collection agency if balances are unpaid after 90 days. Patients assigned to a collection agency may be denied additional service.

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INSURANCE INFORMATION

Please supply us with your insurance information below. We will also request to see and scan your photo ID and insurance card(s) prior to your initial examination and also at future appointments to keep our records accurate.

Primary Insurance: Insurance Company Name _____

Policyholder's name _____ Date of birth _____

Policyholder's ID number _____ Group ID number _____

Copay for specialist $ _____

Secondary Insurance: Insurance Company Name _____

Policyholder's name _____ Date of birth _____

Policyholder's ID number _____ Group ID number _____

Workers' Compensation *(for on the job injury)*: Employer Name _____

Employer Phone _____ Date of injury _____ Claim # _____

AUTHORIZATION

Sign below indicating you have read and agree to the terms in this Financial Policy in addition to the following:

I authorize my insurance company to pay to Lifestyle Eye Center all insurance benefits for services rendered to me. I authorize the use of this signature on all insurance submissions. I authorize Lifestyle Eye Center to release all information necessary to secure the payment of benefits.

I agree that in return for the services provided by Lifestyle Eye Center, I will pay my account (or co-pays/co-insurance) at the time service is rendered and any remaining balance upon receipt of statement (when insurance has been billed and resolved). I understand Lifestyle Eye Center's contracts with health care service plans relate only to items and services which are "covered" by the health care service plan.

I, the undersigned, accept full financial responsibility for any non-covered services, including services rendered before or after the effective dates of any insurance policy. It is understood that the undersigned and/or the patient are primarily responsible for the payment of the bill.

If there are any changes to my medical or insurance status, I will inform Lifestyle Eye Center promptly.

Print Patient's Name _____ Date of Birth _____

Person Responsible for Account – if other than Patient (please print) _____

Signature of Patient or Authorized Party _____ Date _____

If Authorized Party Signs: Print Name _____ Relationship _____