LaFayette Family Optometry

FINANCIAL POLICY

Thank you for allowing Dr. Cecchi, O'Neil, and Smith at LaFayette Family Optometry to provide care for your optometric and ophthalmological needs. Our providers are committed to the success of your medical treatment and care. Our practice will work with you to help fulfill your payment responsibility. Our billing office will file your primary and secondary medical claims for you. It is imperative that you provide us with accurate insurance information at EVERY visit. If you fail to provide the appropriate insurance information, you will be SELF-PAY and we will expect payment at the time of visit. It is important that you realize that we as a medical provider, and you as the insured both have a contract with the insurance company. You may need to assist us, if necessary, with the reimbursement process. **As the insured you are responsible for any unpaid balance not contractually covered by your insurance**. Accounts over 60 days will be charged a $25.00 late fee.

Refraction: Refraction is the part of the examination of your eyes in which we determine the prescription for your glasses. Most insurance companies do not cover this exam. Our providers feel this is a necessary part of the exam to fully evaluate the health of your eyes. Please be aware you will be responsible for the cost of the refraction.

Our fee is $50 for the refraction. You will receive a $10 discount when you pay at the time of service. A 60-day policy is in place from the exam date for prescription checks, remakes on glasses, or contact lens orders.

LaFayette Family Optometry, PLLC is NOT a Medicaid provider: We are only able to bill claims to Medicaid as secondary insurance.

Medicare: This office participates as a Medicare provider accepting assignment for Medicare Part B (Physician Services) claims. The patient is responsible for their Medicare coinsurance, deductibles, and any other service rendered that is not covered by Medicare.

Managed Care Plans: In order to see a specialist, some insurance companies require that you obtain a referral from your primary care provider or a pre-certification before being seen at a specialist's office. It is the patient's responsibility to ensure that we have the necessary paperwork on file prior to your visit or the patient will be responsible for

payment. **ALL COPAYS ARE DUE AT THE TIME OF SERVICE.** If you are not prepared to pay at the time of your appointment, we will reschedule your appointment. **If you are ordering any optical materials (e.g. glasses or contact lenses), we require at least a 50% down payment prior to their order.**

HIGH DEDUCTIBLE HEALTH PLANS: We will collect $175.00 upfront on all high deductible plans. We will bill you for the balance or refund you, depending on your insurance determination once the claim is processed.

Commercial Plans: LaFayette Family Optometry, PLLC. has established fees that are usual and customary for this healthcare service area. Each insurance carrier has its own usual and customary fee schedule. If we are not participating in a plan, you may choose to pay our providers their established fee out of pocket and submit a claim to your insurance yourself.

Non-Covered Services: Not all the services for which we provide will be paid for by insurance. There are services the insurance company may consider not to be medically necessary or that are not a covered service benefit by your specific policy, therefore, if you elect to have an uncovered service you will be responsible for payment at the time of service.

Self-Pay: Patients who do not have insurance coverage will be considered self-pay. Self-Pay patients will need to make arrangements prior to being treated in this office.

Payment Arrangements: LaFayette Family Optometry, PLLC is accepting **CARE CREDIT** for payment in the case you may need to set up a payment arrangement. We do *not* act as a bank, and we do not offer payment plans.

Cancellation Policy: We understand that people get sick or that you may need to change your appointment. If you find that you cannot make your appointment, please allow 24 hours for cancellation. Our time in the office is valuable. When we have a patient no show for an appointment it leaves us unemployed during the time we had set aside for you. If you find that you are not able to keep the scheduled appointment, we ask that you call us and give us notice. There will be a $50.00 no show charge to your account if you fail to communicate your need to reschedule or change an appointment.

Patient Signature: _____ Date: _____