TRI-COUNTY VISION ASSOCIATES, LLC (860) 423-2565
16 Walnut St. Willimantic, CT 06226 fax (860) 423-8058

NOTICE OF OFFICE POLICIES ACKNOWLEDGEMENT

Thank you for choosing us as your eye care provider. We are committed to providing you with quality and affordable health care. Please read & sign our policies below. If you have questions, please feel free to ask any associate.

Insurance. We participate in most insurance plans, including Medicare & Medicaid. If you are not insured by a plan we do business with, payment in full is expected at each visit. If your insurance coverage cannot be verified, we reserve the right to ask for payment in full for each visit until we can confirm your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of the contract you have with your insurance company. If we are not aware of your deductible specifics, we may ask you to make a partial payment at your visit until we can verify the exact amount. Failure on our part to collect co-payments and deductibles from you is considered insurance fraud. Please help us in upholding the law by paying your co-pays and deductibles at each visit.

Non-covered services. Please be aware that some – and perhaps all – of the services you receive may not be covered by your insurer and must be paid in full at the time of your visit. One such example is a Refraction, (the process that determines your best corrected vision or need for eyeglasses). Medicare, along with some other insurance plans, do not offer this as a covered benefit and you will be responsible for the $55 charge.

Referrals. If your insurance requires a referral you must call your primary care physician before your appointment to request this. It is our experience that insurers will not accept referrals dated after you have had your eye appointment. If a referral is not obtained you will be financially responsible for all charges related to your visit.

Proof of identity & insurance. All patients must provide us with a current photo ID & valid insurance card before services are performed. If you fail to provide us with this information before your appointment, we reserve the right to refuse care or require you to pay for the services you receive during your visit.

Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we unfortunately are not party to that contract.

Coverage changes. If your insurance changes, please notify us before your appointment so we can make the appropriate changes to help you receive your maximum benefits. If we are not notified we cannot guarantee your insurer will pay, leaving you financially responsible for our services.

Nonpayment. Please be aware that any unpaid balance over 30 days old will be assessed a 1.5% interest charge monthly and will continue to accrue until paid in full. Non-payment because of a returned check will be subject to a $30 fee in addition to regular interest charges. If your account is over 90 days past due, you will receive a phone call or letter stating that you have 14 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated ahead of time. After this time, we may place your account in collections and you will be responsible for any and all fees associated with this action. In addition, you may be discharged from seeking future services from this practice. If this is to occur, you will be notified by one or more of the following ways: regular mail, certified mail, email or phone that you have 30 days to find alternative medical care. During that 30-day period we will only be able to treat you on an emergency basis.

Missed appointments. If you do not show up for a scheduled appointment or do not give us *24 hours advance notice* that you will not be coming, we reserve the right to charge $50 per missed appointment and/or in the case of frequent missed appointments we may: not place you on appointment cancellation lists, not offer you future regular appointments and/or dismiss you from our practice. Please help us to serve you and others better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Thank you for reading and understanding our office policy. Please let us know if you have any questions or concerns.

By signing below, I understand and acknowledge the terms stated above. I agree to accept financial responsibility for all services or supplies received by me/my dependent(s). I understand that exact insurance benefits cannot be determined until the health plan receives the claim. I authorize direct payment from my health insurance plan to Tri-County Vision for all services and supplies provided to me/my dependent(s). This is a direct assignment of my rights and benefits under this policy and will remain in effect until revoked by me in writing. I have been given the original copy of this office policy.

_____ _____

PRINT: Patient Name SIGN: Patient or Parent/Guardian

_____ _____

Date PRINT: Parent/Guardian's Name

FOR OFFICE USE:

Unable to obtain signature. Reason: _____

Staff Name: _____ Initials: _____ Date: _____