Middle Creek Eye Center Financial Policy and Disclosure

In order to provide the best medical care, we ask that you do not discuss your account balance or financial aspects with the physician(s) or medical staff. Please discuss any account information with the check out associate or front desk.

Dedicated to providing the most efficient and reasonable eye health and vision care services to you and your family, our office feels that your understanding of the financial and disclosure policy is also an essential component of the care. Therefore, it is necessary for us to have a Financial Policy and Disclosure stating our requirements for payment for services provided to patients.
All comprehensive exams at Middle Creek Eye Center, Inc. which includes Diabetic Eye Exams consist of a full eye health evaluation, which includes assessment for glaucoma and cataracts and a refraction to evaluate the visual system. Refraction Service is usually considered a **"non-covered"** service with most medical insurances. A Contact Lens Evaluation is an optional **"non-covered by medical insurance"** service which is an **additional** charge and may be performed on the same day or within thirty (30) days of the routine eye exam.

Patients are responsible for the payment of all services provided by Middle Creek Eye Center Inc and its affiliates. Methods of acceptable payments are ***Cash, LOCAL Bank Check*, CareCredit*** or ***Visa/MasterCard/Discover.*** **When paying by check, the account holder expressly authorizes Middle Creek Eye Center, Inc. to electronically debit your bank account for the amount of the check. If the check is dishonored or returned for any reason, an additional processing fee of **$30** (or legal limit) plus any applicable legal fees will be charged. The use of a check for payment is the acknowledgement and acceptance of this policy and its terms.*

Self-Pay Policy
- If you are a self pay patient, you will be required to pay an estimated amount for the exam before services are rendered.
- Any remaining balance on your account will be collected at check out.

Medical and Vision Insurance Policy*
- If you are an insurance patient**, it is our policy to file for insurance as a courtesy to you. We must have accurate and complete insurance information at the time of service.
- If a service is provided that is not covered by your insurance company, you will be the responsible party at the time of service.
- If we have not received a payment from your insurance company within sixty (60) days, you will be responsible for the balance due.
- Estimated deductibles, co-payments, and estimated coinsurance will be collected before services are rendered for insurances we participate. The insurance company will determine the final financial distribution.
- In special cases, we may need your help in contacting your insurance company for the payment of your services.
- Due to insurance company regulations, vision and medical insurances may **NOT** be filed on the same day of service.

*Our office will ONLY file to participating insurances. It is ***the patient's responsibility*** to provide our office with accurate billing information and to understand the insurance benefits and financial coverages. If the insurance plan requires a ***referral***, the patient is responsible to obtain the referral before the exam. If our office is not able to verify your insurance coverage on the date of service, you will be required to pay in full. Our office will still try to file with your insurance and any refund will be issued if applicable. **Non-Local patients are required to pay in full even if insurance is presented and an itemized receipt will be provided to the patient to file with his/her insurance. Upon request, our office may try to file with your insurance and any refund will be issued if applicable.

Divorce/Custody Case/Personal Representative Policy: The parent or guardian who brings the patient into our office will be held financially responsible, regardless of the provisions in the divorce decree, who has custody, or who has the insurance. For situations where the patient is not able to sign legal documents, the personal representative, such as Power of Attorney, must provide notarized copies of necessary legal documents, must be available to sign all documents, and must be present during the exam.

Worker's Compensation Policy
- If you are a worker's compensation patient, it is our policy to bill your employer or the worker's compensation carrier for services rendered.
- If payment is denied from your worker's compensation carrier, you will become responsible for the entire balance of your services. Payment will be due within ten (10) days following any worker's compensation payment denial.
- It will be your responsibility to contact us with the name and address of your employer or the insurance company that covers your employer.

Overdue Balances: All over-due patient balances will be charged at a rate of five dollars ($5) per month. Balances over two (2) months old will be handled by Transworld Collections Agency Billing Department. All over-due balances over ninety (90) days will be sent to Transworld Collection Agency Collections Department. All accounts sent to collections will be charged a $50.00 collection fee in addition to the account balance.

Material Purchase and Refund Policy: If materials are to be ordered, **at least 50% payment** will be required at the time of the order. The remaining balance will be due when you receive your materials. There is a **30% cancellation fee*** on non-dispensed frames within ***60 days*** of purchase/order date. All spectacle lenses are custom made and therefore are **nonrefundable**. All dispensed frames are **nonreturnable and nonrefundable**. Any unopened, unmarked, undamaged and non-expired boxes of soft contact lenses purchased from our office may be returned and refunded minus a **30% processing fee***. There is a **30% cancellation fee*** on RGPs (rigid contacts) and soft contact lens orders within ***30 days*** of purchase/order date. **NO REFUND** on RGPs after ***30 days*** from purchase/order date. **NO REFUND** on budget packages, any professional services, and insurance-filed purchases. Our office reserves the right to cancel any orders not picked up after 60 days from purchase/order date and NO REFUND/CREDIT will be issued. **Cancellation and processing fees are calculated from the original cost before any discounts.*

To help in this policy we ask that you assist us at the time of service by:
1. Providing us with current and updated information on yourself and your insurance company.
2. Presenting an updated photo identification card and insurance card when changes are made.
3. Making the appropriate payment at the time of service, whether it is a deductible, copay, coinsurance, or for the full amount if you are a Self-Pay Patient.

By signing below: *I have read and understood the financial policies of Middle Creek Eye Center, Inc., and also I understand that Middle Creek Eye Center, Inc. reserves the right to change any and all fees at any time without notice. I request that payment of authorized Medicare, BC/BS of TN, and all other insurance companies' benefits be made on my behalf to my attending physician for medical services furnished me. I authorize the release of any medical information about me necessary to determine benefits for related services. I agree to pay any amount not covered by my insurance at the time services are rendered and authorized my insurance to pay my doctor directly. I further agree in the event of non-payment to bear the cost of in house collection at a rate of **$5 per month** of the total bill in addition to the amount of the total bill, court costs, interest at the legal rate and reasonable attorney fees should this collection procedure be required.*

SIGNATURE (Patient/Guardian)X: ________________________ **Date:** ______ / ______ / ________

Property of Middle Creek Eye Center

DISCLOSURE AUTHORIZATION/CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

TO SHARE OR NOT TO SHARE: PLEASE HELP US OUT WITH THAT QUESTION!

I, ____,
(name of patient/minor/dependent)

_____ **DO NOT authorize *the Office of Middle Creek Eye Center, Inc.* to disclose any of the health information listed below to the any individual but myself.**

_____ **DO authorize *the Office of Middle Creek Eye Center, Inc.* to disclose my selected health information that are checked below only to the specific individual(s) indicated below.**

Specific description of information to be used or disclosed:

____ Specific Personal Information such as:

____ Account Information ____ Appointments ____ Financial Information ____ALL

____ Specific Exam Information such as:

____ Diagnoses ____ Medical Treatments and Procedures ____ Spectacle and/or Contact Lens Prescriptions ____ALL

____ Pick Up Materials such as:

____ Contact Lenses ____ Spectacles ____ Samples of Medications ____ALL

____ Other description and reason: ______________________________

Name of the persons/entities/doctors to whom this practice will give my information:

(name)	(relationship)	(phone number)
(name)	(relationship)	(phone number)
(name)	(relationship)	(phone number)

This authorization will expire on the following:

____ **Date:** ______________________

____ **Event (relating to patient or the purpose of the disclosure):** ______________________________

I understand that my records are protected under federal regulations governing Confidentiality of Patient Records, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except of the extent that action has been taken in reliance on it, and that in any event this consent expires automatically or as stated above.

Signature: ______________________________ **Date:** ______________________

Relationship to patient: self ______________________