Horizon Eye Care Group

Financial Policy

Thank you for choosing Horizon Eye Care Group P.C. for your eye health care. The following is a statement of our financial policy. Please read and sign this policy before being examined in our office.

Insurance

Your insurance policy is a contract between you and your insurance company. We will submit insurance claims to your insurance carrier for services rendered if you have given us complete and accurate insurance information. We must have the correct policy, group, ID or claim numbers, and mailing address. Please be aware that some, or perhaps all, of the services provided to you may be non-covered services according to your insurance policy. You are ultimately responsible for payment of all services provided to you.

If you have an insurance plan we do not participate with, we will request payment at the time of service for all office visits and a 20% down payment for any surgical procedures that are performed.

For a full list of insurances we accept, ask one of the office employees. Even if we accept your plan, you may be responsible for payment of the office visit, deductible, co-payment, co-insurance, or non-covered services. These charges will be collected at the time of service.

Our Billing Process

- We will file an insurance claim with your insurance company within two days of your date of service.
- If we do not receive a response from your insurance carrier within 31-60 days, we will submit a second claim.
- If we do not receive a response from your insurance carrier within 61-90 days, you will receive a statement and you will need to contact your insurance carrier regarding payment, the balance due for medical services rendered to you will be your responsibility.
- A billing statement covering rendered medical services will be mailed to you on an “every four week” basis.
- After 120 days from the original date of claim submission, we will place your account with our collection agency. Patients are responsible for any collection cost that may apply.

We accept cash, personal checks, Visa, MasterCard, and Discover as payment. In the event that a personal check is returned from your bank for non-sufficient funds, your account will be charged with a $10.00 returned check fee. You will not be allowed to pay with personal checks in our office again, but instead must pay in the form of cash or credit card.

If an extended payment plan has been offered to you, we require monthly payments or the plan is considered void. Voiding of the plan will result in collection service activity.

If you have a financial problem, please ask to discuss a payment plan with our billing manager or office manager.

Disability Form Preparation

If you have disability forms that need to be completed by our office we will complete the first form free of charge. Any additional forms will be billed at $5.00 per form. We attempt to complete these forms as quickly as possible, but it is possible several days will be needed in order for the forms to be prepared.

Glasses

We require a 50% deposit on your glasses before they can be ordered. Once they are ordered the Optical Shop will call you shortly after they arrive. You must pay the remaining balance at the front desk before picking up your glasses. All frame sales are FINAL.

Minor Patients

The patient/guardian/adult who is accompanying a minor child is responsible for all payments. Any child eighteen years, or older, is legally an adult and responsible for his or her bill. This is true regardless of whether he or she is attending college, living at home or being covered by a parent's insurance policy. If both parents have insurance, the parent with the first birthday in the year is most often the primary insurer. Please check your insurance policy to determine which company is primary before coming in to our office. In divorce cases, the parent who brings the child in for medical services is ultimately responsible for payment in full for services rendered.

Collection Balances

If you had a previous collection balance, or are currently in collection, the physician may use his or her discretion regarding future care. It is likely that you will be required to pay your previous balance, in full, prior to being seen. You will be responsible for payment of the office visit, co-payments, deductibles, non-covered services, ect., on the day of the visit.

Cancellation Policy

Please help us to serve you better by keeping your scheduled appointment. We request twenty-four hour notice if you are unable to keep your appointment with us.

I have read the above financial policy and agree to the terms described in it.

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Signature of patient/responsible party ***Date***