FOX VALLEY OPHTHALMOLOGY'S FINANCIAL POLICY

Thank you for choosing Fox Valley Ophthalmology as your health care provider. The doctors and staff are committed to providing a successful outcome in a pleasant environment. Your clear understanding of our Financial Policy is an important part of the doctor/patient relationship. Please feel free to inquire about our fees or Financial Policy.

-All patients should complete our "Patient Registration Form" prior to seeing the doctor.

PAYMENT FOR ROUTINE VISION EXAMS IS DUE AT THE TIME OF SERVICE
WE ACCEPT CASH, CHECKS, VISA/MASTERCARD AND DISCOVER.

UCR (Usual and Customary Rates)

Our practice will provide the best treatment possible to our patients, and charge what is usual and customary for our service area. Understand that you are responsible for full payment of services rendered regardless of an insurance company's arbitrary determination of fees.

MINOR PATIENTS

For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized by VISA/Mastercard; or unless cash or check payment has been previously verified. The accompanying adult, and parents or guardians are responsible for payment in full for services rendered to a minor.

REGARDING INSURANCE

Your co-pay is always due at the time of your visit, as stated in the terms of your insurance policy. Failure to comply with those terms will result in an additional $25.00 service charge.

In the event of a medical diagnosis, our office will file a claim on your behalf to your insurance carrier. If your insurance company has not paid the claim within 60 days, you will be billed for the balance of your account. There will be a $25.00 monthly re-billing fee on statements not paid within 30 days. Please be aware that some, and perhaps all of the services provided may be "non-covered" services; not considered necessary under the Medicare Program and/or other medical insurance.

Insurance is a contract of benefits between you and your insurance company. Fox Valley Ophthalmology, although a provider of services, is NOT a party to your contract with your insurance company. You are responsible for the timely payment of your account.

Thank you for cooperating with our Financial Policy. Please call our Billing Office with any questions or concerns.

X____

Signature of Patient or Responsible Party Date

REGARDING FOX VALLEY OPHTHALMOLOGY'S "NOTICE OF PRIVACY PRACTICES"

When you visit our office, you will be given a copy of our "Notice of Privacy Practices." It provides you with information about how we may use and disclose your Protected Health Information. Please read the "Notice" when you arrive at our office and if you have any questions, please contact our HIPAA Privacy Officer.

Upon receipt of our "Notice, " please sign below:

I have received a copy of Fox Valley Ophthalmology's "Notice of Privacy Practices."

X____

Signature of Patient or Legal Representative/ Relationship to Patient/ Date

Revised 7/17/09